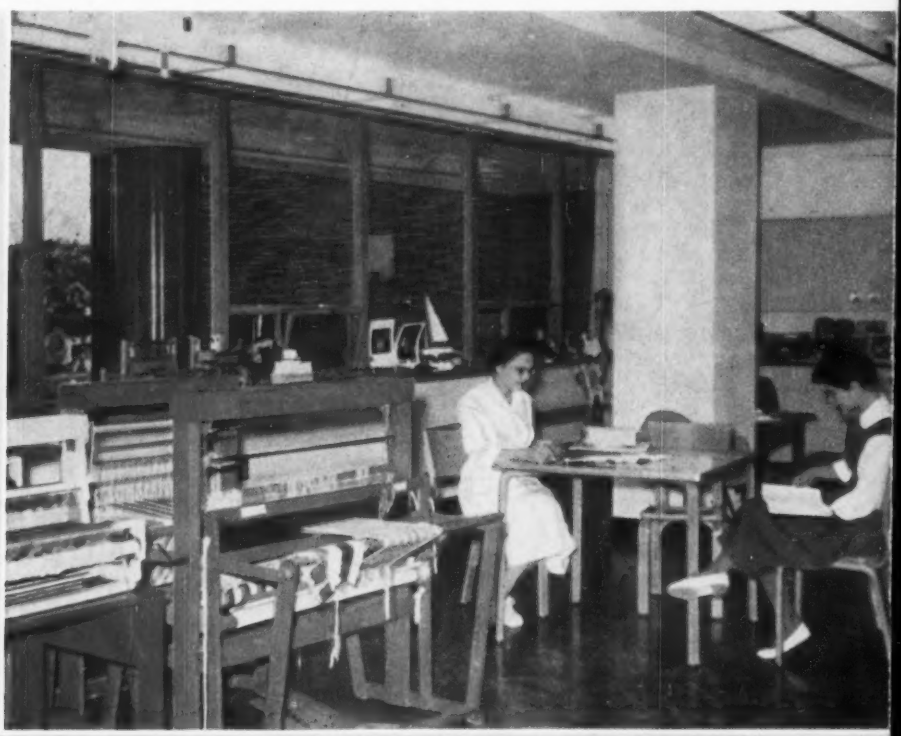
The Modern Hospital

OCTOBER 1957



OCCUPATIONAL THERAPY SECTION, CHILDREN'S ORTHOPEDIC HOSPITAL, SEATTLE (Page 63)

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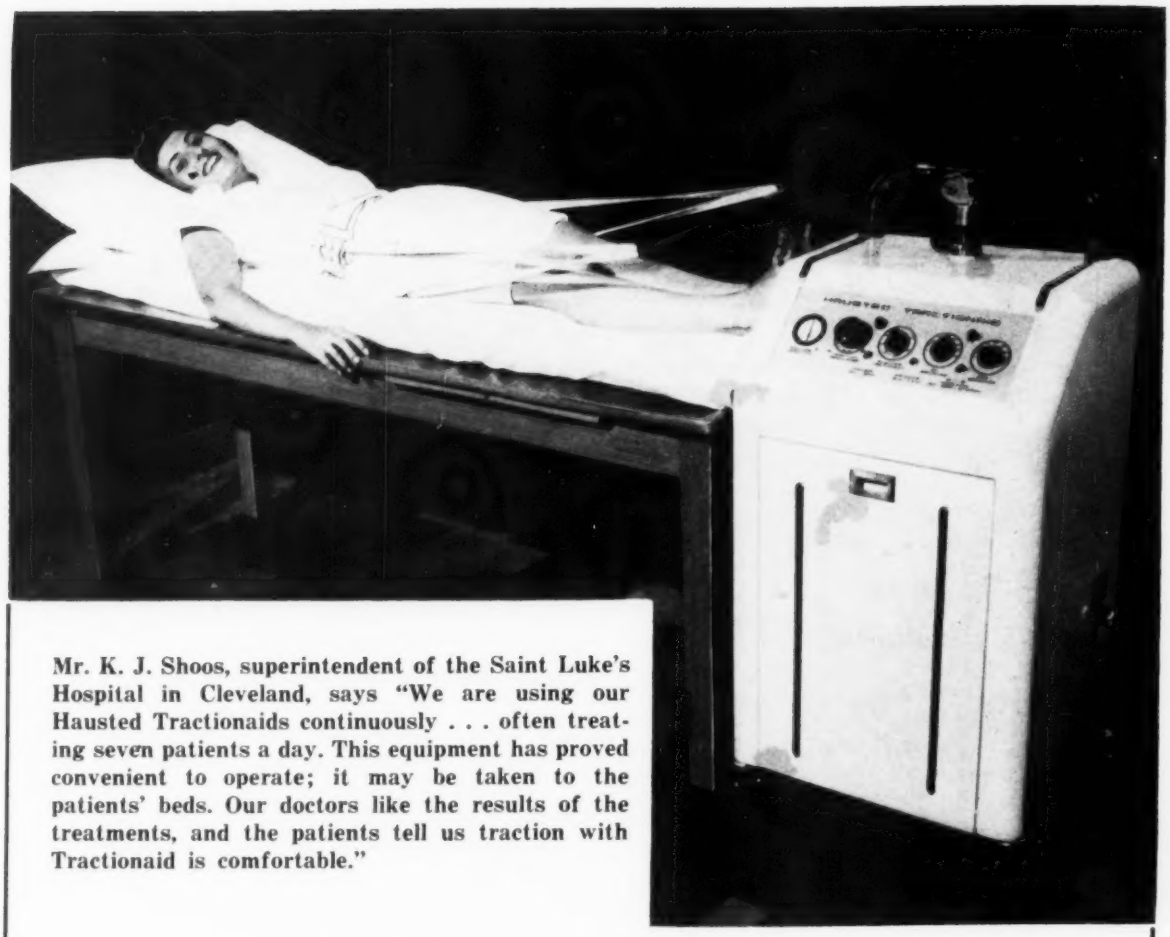

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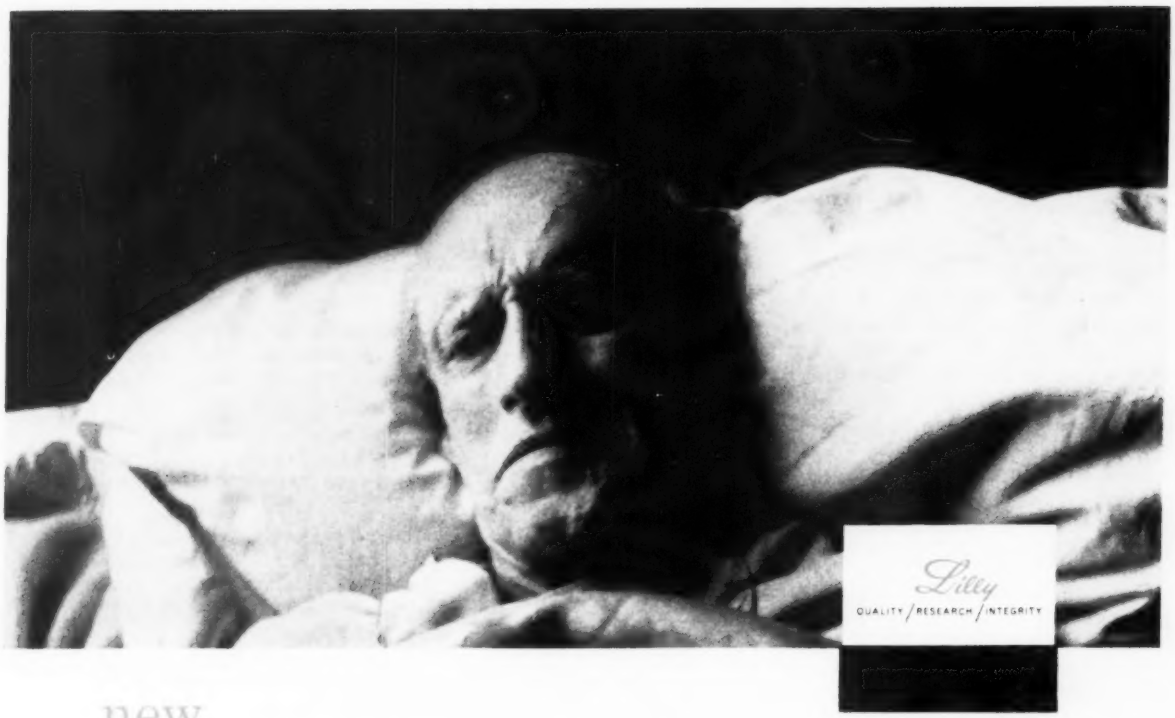

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1. *Gruber, C. M., Jr.: J. A. M. A.*, 164:966 (*June 29*), *1957.*

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AMONG THE AUTHORS

Isabella Tremor

The usual nursing manual does not give much thought to the inclusion of all workers in each procedure, says **Isabella Tremor** in her article on page 69. To remedy this, she has designed a nursing manual in which the procedures fix responsibility and accountability for performance, designate duties according to skills, and define the responsibility for supervision, thus eliminating the need for more than one procedure manual. Miss Tremor is a graduate of Uniontown Hospital School of Nursing, Uniontown, Pa., and holds a master's degree in nursing education from New York University. Currently she is director of nursing service at Cincinnati General Hospital, Cincinnati. In addition to her administrative experience, she has had teaching experience at both the graduate and undergraduate levels. Her interest and research in nursing procedures stem from her desire to have better nursing care with the safe and efficient use of nonprofessional nursing personnel on the nursing team.

Maxine Bishop

Even the best laid plans for employe communications programs can go awry, but every one that is successful brings administration and employes that much closer together. On page 91, **Maxine Bishop** discusses some of the personnel programs she has tried at Mount Zion Hospital, San Francisco. Some were unsuccessful, and Mrs. Bishop gives the reasons. Others were workable, and she explains their operation in the hospital. A transplanted Virginian, Mrs. Bishop has been director of personnel at Mount Zion for the last four and one-half years. Previously she worked as a position classification analyst for the U.S. Civil Service Commission; as an associate in a personnel and management consultant firm, and as a personnel technician for the University of California Medical Center, all in San Francisco. Mrs. Bishop is a member of the American Management Association and the Society for Personnel Administration.

Microwave cooking, no longer considered as part of the world of Jules Verne, is taking its place in today's kitchens. Microwave ovens that complete cooking in minutes have been installed at Kaiser Foundation Hospital, Harbor City, Calif. On page 108, **E. R. Park** and **Evelyn D. Ibata** describe how this has modified and speeded up their food service, and the economies that have resulted. Mr. Park has been administrative-dietary consultant for the Kaiser Foundation Hospitals for the last four years. Prior to joining the foundation staff, he was associated with Purdue University for eight years, as assistant to the manager, and later as manager, of the men's residence halls. He is a graduate of Purdue. Mrs. Ibata, who is head dietitian at the Kaiser Foundation Hospital, took her bachelor of science degree at the University of California at Berkeley. She served her dietetic internship at St. Mary's Hospital, Rochester, Minn., and was dietitian at St. Anne's Hospital, Chicago, and Seaside Memorial Hospital, Long Beach, Calif., before she took her present position in Harbor City. She is a member of the American Dietetic Association.

Certain qualities usually mark a successful administrator, no matter where his hospital may be. So says an Englishman, **S. G. Hill,** who describes the personal characteristics of a good leader on page 57. Mr. Hill is secretary of the Northampton and District Hospital Management Committee and a past president of the Institute of Hospital Administrators.

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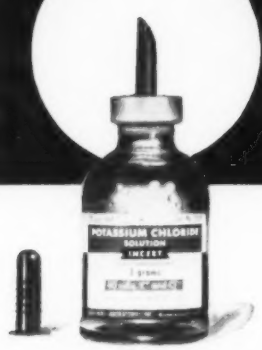

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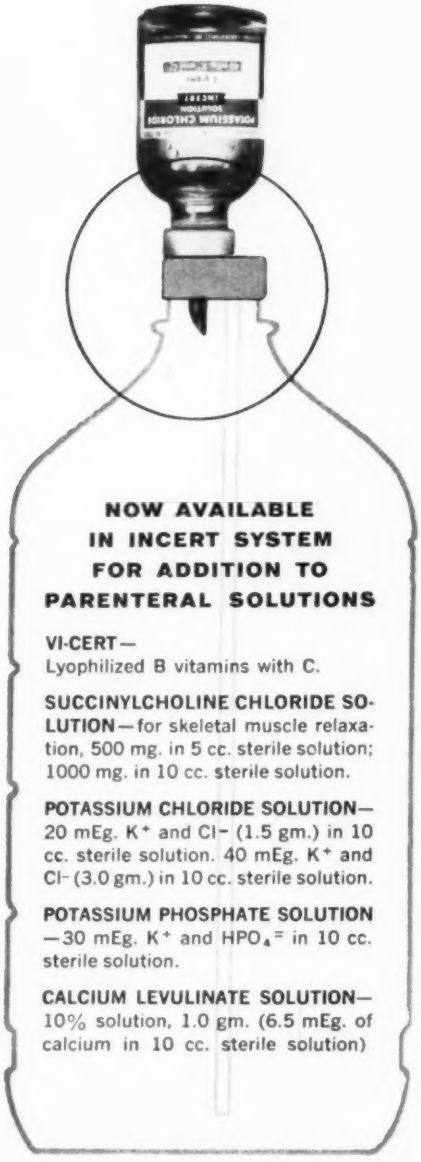

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ROVING REPORTER

Nursing in West Germany

West Germany sparkles on the industrial scene. Its glitter tends to divert attention from segments of its people whose fortunes are yet to rise. The German nurse, according to *Der Spiegel*, a *Time*-like weekly of Hamburg, is still a Cinderella. For her there is no golden coach, not even a Volkswagen.

She works under conditions which include the worst features of cartels and of labor unions. Her battle in the Bundestag to improve her working conditions recently was defeated by entrenched interests. The tale is one of privilege and pride, of cupidity and coercion, of reliques and religion.

For centuries the Catholic religious orders looked after the sick. About 125 years ago, the first Protestant or deaconess organization was founded, one of the early instances of the emancipation of women. The nurse's cap was the contemporary headcover of the married woman, and the nurse had the social privileges of a married woman, including the right to visit a home unaccompanied.

A little later the Motherhouses of the Red Cross came into existence, a society not to be confused with the International Red Cross or its national components. It combined patriotic and philanthropic aims.

In 1860 it inaugurated the first nursing course, and soon had motherhouses throughout Germany. Its nurses submitted to a nun-like set of rules. The house mother had parental authority over them, and they performed their duties not as a profession but from national and social awareness. Their services were compensated for by their being treated as members of a family, under the protection of the motherhouse until the end of their lives.

Things went well until the end of the Nineteenth Century. The Red Cross members received a professional education, had professional status, were well paid, and were under a form of social security.

With the industrial rise of Germany about 1900 there came a great increase in the number of hospitals, clinics and asylums, and the existing nursing groups could not meet the demand for their services. True, there were many young women who were eager to become nurses, but they were unwilling to submit to the restrictive rules. For example, it was a burning problem whether a nurse could visit a theater while off duty. In 1903, a former Red Cross nurse founded a nursing organization for those who did not wish to enter a motherhouse or an order, but who wished to look after the sick.

The motherhouses regarded the new group as endangering the profession. The deaconess societies forbade their nurses from having any thing to do with the "mavericks." Catholic leaders were against the lay nurse. The established sector could not directly hinder the rise in the number of nonreligious and non-Red Cross nurses, but it could make it virtually impossible for the latter to obtain employment. Restrictive agreements came into being; these still are used. What is worse, the groups of nurses who were the

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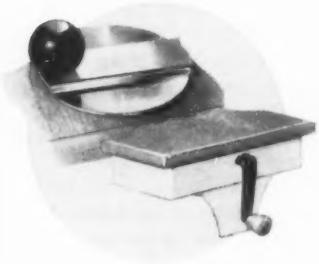

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first victims of the new tactics also came to use them, and still do.

A contract is made (the first such agreement was arranged in 1640) between a hospital or clinic and a nursing organization. Larger units may replace the hospital: city, town, university, foundation or church group may be a contracting body. The nursing-contractor agrees to furnish as many women as are needed for the proper function of the hospital. The latter is relieved of all the obligations it would ordinarily have when engaging individual nurses.

The contract price, paid to the head of the nursing organization, is based on an average wage, which disregards age, length of professional service, or prior achievements of the nurses.

The hospital-contractor seeks to pay the lowest price. Its search for bargains is aided by the fact that hundreds of nursing groups are competing for the business. These include 220 Catholic orders, 72 deaconess orders, 49 Red Cross motherhouses, 28 Evangelical and eight Catholic nurses' societies.

The result? The contract price is usually about 35 per cent below the standard officially agreed upon in negotiations between nursing unions (who practice restrictive covenants) and governmental units (federal republic, provinces and cities).

The nursing-contractor pays the nurses, first retaining that portion which it thinks it should have. The Red Cross head calls this "the expression of our concern for our nurses. The motherhouse relieves them of all care." The director of the local nursing unit is the only person in the hospital who is responsible for every facet of the nurse's professional, and sometimes even social, life; doctor and hospital administrator have only limited supervisory powers.

The director can transfer nurses from one contracting hospital to another, whether or not there are valid grounds for the hospital's dissatisfaction. If a nurse finds her place of employment uncongenial, on the other hand, but the director chooses to ignore her request for transfer, she has only one recourse—to leave the parent group.

Such a step has many disadvantages. The dissident nurse loses all claim to sickness pension and to care in old age for which she has been paying, perhaps for years; the withheld portion of her pay often amounts to 50 per cent or more of the contract price. What is more, she cannot be employed as a "free" or unorganized nurse by any hospital with which her former organization has a contract, usually for at least two years.

She may, however, seek employment with her former association, but without the advantages she formerly enjoyed, such as free uniforms and vacations. Her pay, of course, is below that set in the official negotiations described. She cannot hope to rise professionally because all supervisory personnel are members of the nursing-contracting group. She loses her position if another nursing-contractor takes over the hospital. After the age of 40 to 50 years, the "free" nurse finds it difficult to obtain permanent employment. The "regular" organizations prefer to employ untrained help rather than give work to a "free" nurse.

The shortage of nurses is as pronounced in Germany as elsewhere. At present, there is one nurse for each nine beds, although as far back as 1938 a ratio of 1:6 was prescribed. Were that regulation observed, there would be need for almost 30,000 addi-

tional nurses. This number does not include those required were the federal republic to provide the 70,000 hospital beds still lacking.

How is the deficiency made up? There is widespread use, by nursing-contractors, of untrained personnel. Even among the qualified nurses of the contractor there is often a minority of its own members; the remainder are "free" nurses who have submitted to the conditions of employment of the orders or motherhouses. The latter cannot obtain enough young recruits, but rather than give up their protected positions, they use the services of the "free" nurses, much to their financial advantage as well as to that of the hospital-contractor. Thanks to loopholes in working regulations, the hospital saves various, otherwise obligatory, expenditures.

For several years attempts have been made to obtain federal regulation of the nursing profession and thus check the powers of the orders and motherhouses. Within the Adenauer government, the C. D. U. (Christian Democratic Union), the nurses found some understanding ears, but they did not reckon with the influence of the powers-that-be in nursing.

The latter employed all the arguments of invalid tradition and the appeals to nonexistent ideals, and the progressives were defeated. The proposed legislation included such radical measures as the introduction of a 51 hour work week, a limit of 9½ hours in a single day, and a 48 hour week for nurses in operating rooms and in infectious disease units. All sides agreed, however, to define more clearly what is meant by the word "nurse."

Defeated also were attempts to make legally obligatory a three-year course in training for nurses, so that German nurses might measure up to international standards. The woman physician, who serves as health authority for the C. D. U. representatives in the Bundestag, remarked, "Who wants educated nurses?," while the head of the Red Cross motherhouses agreed that the incursion of academic nurses would endanger the ethical status of German medicine.

The picture is not everywhere dark. In Hamburg, Berlin and other cities, nurses in municipal institutions have all the rights and privileges of other municipal employes. The director of the municipal hospitals of Karlsruhe hires nurses on an individual basis, pays them the official salary, limits the work week to 54 hours (60 hours is quite common), builds them modern housing, organizes vacations at reduced rates, restricts the wearing of uniforms, permits "decent" make-up, and allows nurses to continue working after marriage. His success can be measured by the fact that there are a dozen applicants for every vacancy on the nursing staff of the Karlsruhe hospitals.

That German young women want to become nurses, but in terms of the mid-Twentieth Century, is demonstrated in Heidelberg. There the municipal nursing school has no openings until 1962. Its examination is the only one in Germany which, says *Der Spiegel*, is accepted abroad. Its director found only hindrances in her efforts to do the same things in the Red Cross motherhouse, which she was obliged to leave after 19 years of service. The Red Cross motherhouse, by the way, finds it necessary to advertise in the daily press for nursing students, and in vain.—S. M. RABSON, M.D., *Los Angeles*.

Gone Fishing: Back Soon

The month of September signals the end of the fishing season and, like all enthusiastic anglers, the mental patients at the Veterans Administration hospital in Tomah, Wis., were sorry to see it approach.

During the fall and winter months, the patients start preparing for the fishing season in occupational and manual arts shops by making fishing plugs and tieing "flies."

With the beginning of warm weather, patients are out on the hospital grounds to practice casting into automobile tires arranged at various distances and angles. They use hookless "plugs" in the practice sessions, guided by fishing instructors.

The trout season opens May 1 in Wisconsin. From May through September the fishermen are driven by bus three times a week to near-by lakes for morning and afternoon fishing parties. Last year, 400 patients regularly participated in the trips.

The fish that are caught are served to the anglers in fish frys held on the hospital grounds, or at dinner in the wards whose patients caught the fish.

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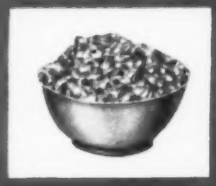

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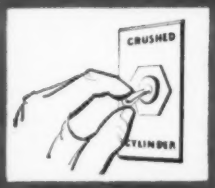

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To Get a Good Press, Try to Think the Way a Newspaperman Thinks

By GORDON DAVIS

Gordon Davis

ONE of the delightful opiates that bind public relations people to their work is the opportunity to make a lifetime career of telling others how to run their business.

Find yourself a frustrated public relations worker and 10 to 1 you've found one to whom nobody pays any attention.

The yen to illuminate the lives of the less enlightened is an impulse which cannot be denied. It rewards parenthood and inspires educators and the clergy and leads to the authorship of innumerable columns such as this one.

It also moves people from all walks of life to offer solemn advice to hospitals on how to operate hospitals, and it encourages hospital administrators to shake admonitory fingers at the professionals in other specialties.

Newspaper editors, for instance. How often have you heard hospital people expound on the sins, misdeeds and inconsistencies of the press? How often have you heard them state explicitly and in detail exactly how a specific story or headline should have been handled?

The implication is plain: The editor or reporter in question just didn't know his business.

We who criticize the press could be right on occasion, just as the press is sometimes right in criticizing hospitals. That is the theory behind freedom of speech: It checks the human impulse toward omniscience. But criticism is seldom right if it is uninformed, and newspapers and hospitals alike are justified in protesting irresponsible fault-finding.

Most hospital sins against the press are not deliberate but are based on lack of knowledge of what constitutes news and of how news is processed.

News is a report of the unusual. Ordinary, everyday good behavior is not unusual; therefore it is not news; therefore front pages reek with reports of human peccadilloes and misfortunes. It is to read about the unusual that people buy newspapers. The editor who tries to feed the commonplace to his readers doesn't last long as an editor.

Appreciation of these facts should be the starting point for every evaluation of newspaper conduct. Those who adhere to this principle will not waste energy battling the inevitable. On the contrary, their understanding of the editor's problems is the best possible foundation for mutual esteem.

Even ordinary activities often have aspects or angles that lift them out of the humdrum. This is one of the reasons why reporters ask so many questions. They are looking for newsworthy angles. The better the reporter, the more he digs until he gets an angle. He will cherish, admire and support the administrator who helps him in this process.

A basic rule for good press relations thus is to begin with the assumption that the editor and the reporter know their business. They want true news; they are hungry for it. If you appreciate what constitutes news from their point of view rather than your own, and if you adapt this knowledge constructively to your own activities, your hospital is almost certain to achieve a good press.

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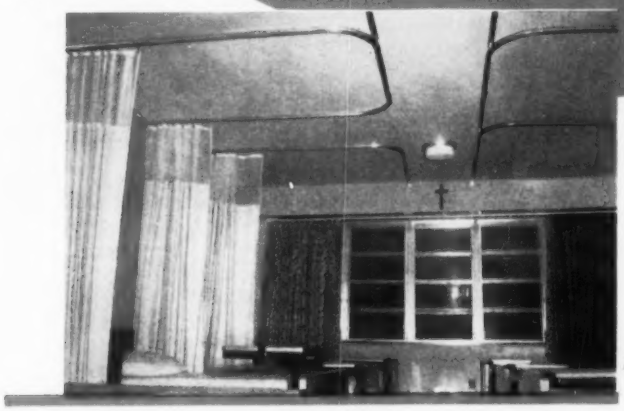

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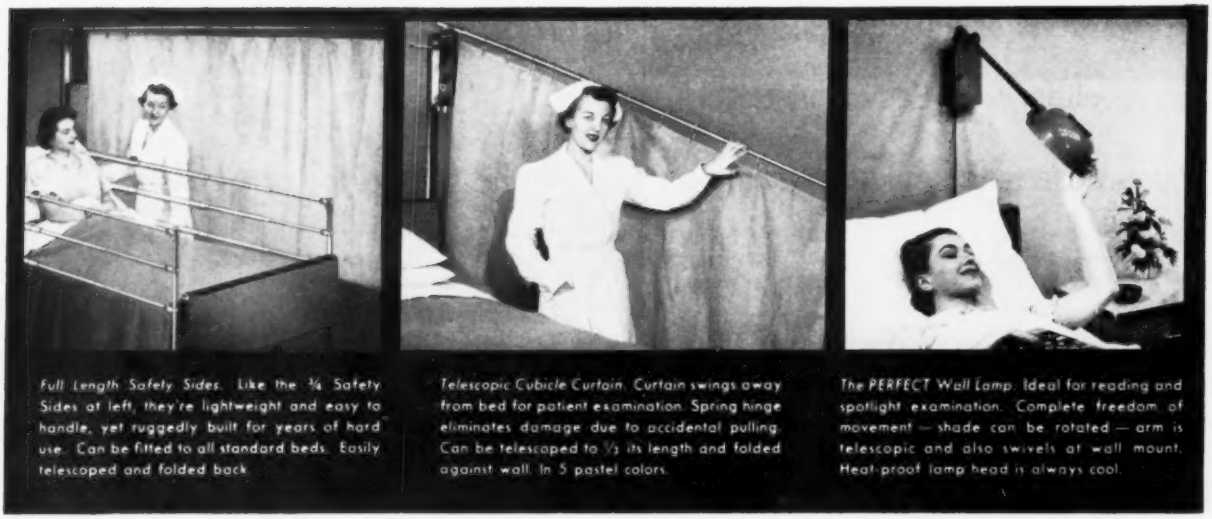

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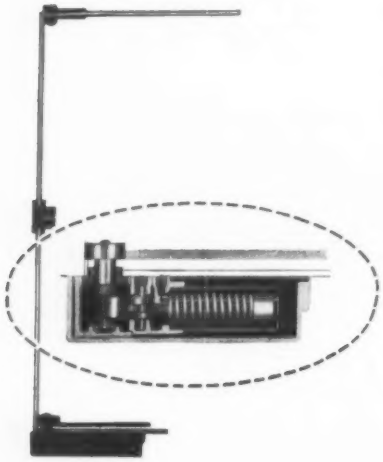
Strong, trouble-free, shallow door closers . . . firmly embedded in the rigid floor . . . no arms or closer mechanisms visible on either side. Easy to install or adjust. Write for complete details.

The City-County Building, Detroit, Michigan
HARLEY, ELLINGTON AND DAY, INC., Architects



ideal for *school classroom doors • hospital patient room doors • hotel guest room doors • office building and factory interior doors . . .*

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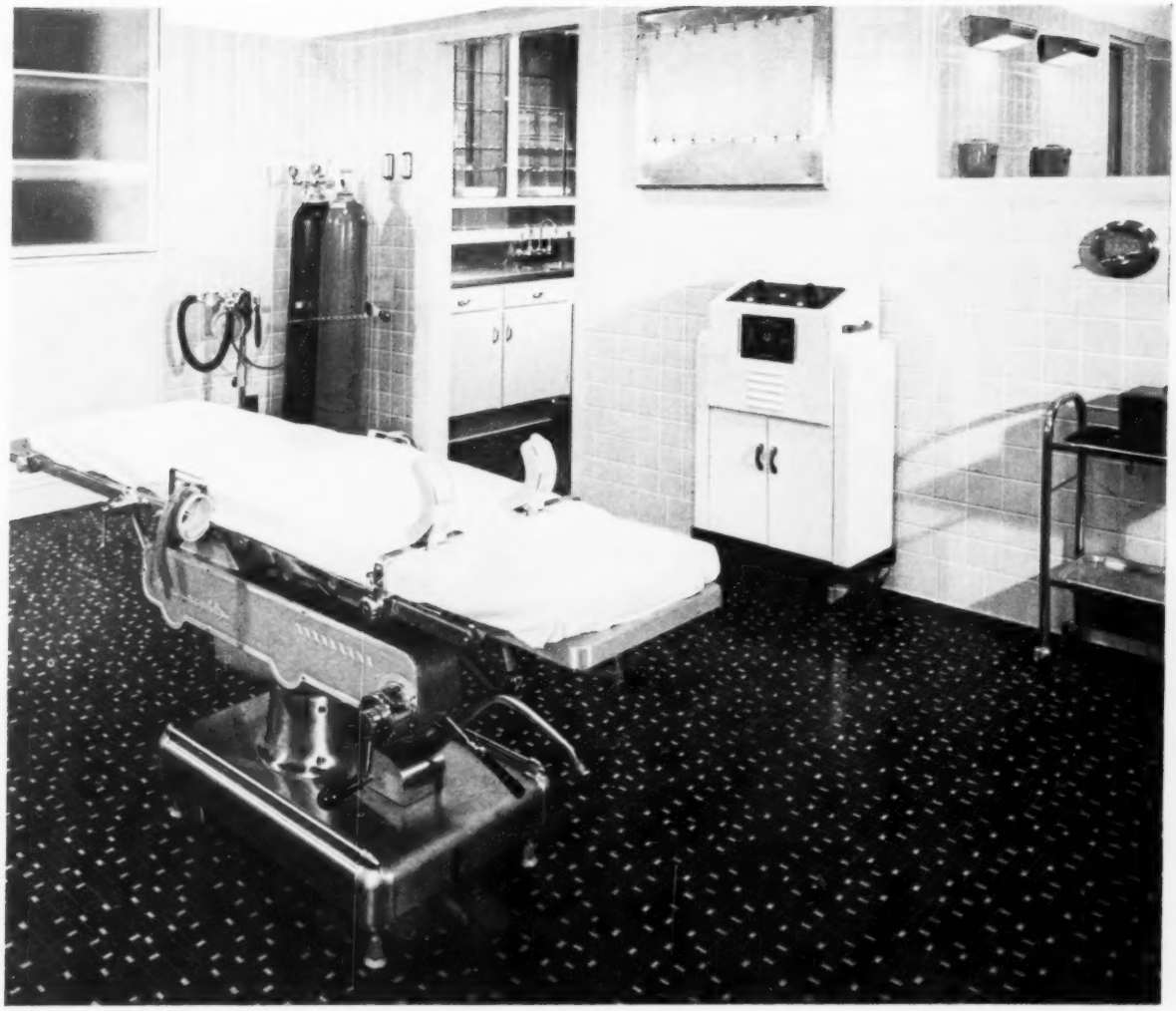

CERAMIC TILE—
for maximum safety . . . minimum maintenance

Walls and floors of spic-and-span ceramic tile are a hospital's best guarantee of years of trouble-free performance. Easiest to keep sanitary . . . lowest maintenance costs . . . *permanently* bright and cheerful.

Conduct-O-Tile for floors in operating rooms and adjoining areas safely eliminates dangerous accumulations of static electricity, the main cause of anesthetic explosions. Conduct-O-Tile is permanently conductive —needs no waxing or other special treatment.

TILE SPECIFICATIONS: Color Plate 350. Operating Room, North Penn Hospital, Lawrie and Green, Architects. Walls: 55 Fern Green. Floor: Block Random, Sprinkle Pattern, ¾" x 1⅝" series, Jet Conduct-O-Tile and Turquoise Shadowflash.

NEW FREE BOOKLETS *give you full information on ceramic tile, abundant suggestions for hospital installations. Send for your copies today.*

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Please send me, without obligation, your free booklets:

- ☐ Booklet 600, "Tile for Schools and Hospitals."
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DEPENDABLE

Make this simple test!
Prove to yourself that the

DEKNATEL PLASTIC PAK will not leak!

- **HERMETICALLY SEALED—NO LEAKAGE**

  Squeeze a Deknatel Pak with all the strength of your fingers. The seal will *not* break. Actually, every Deknatel Plastic Pak is tested for leakage by a pressure markedly exceeding all practical requirements.

- **STERILITY TECHNIQUE UNCHANGED**

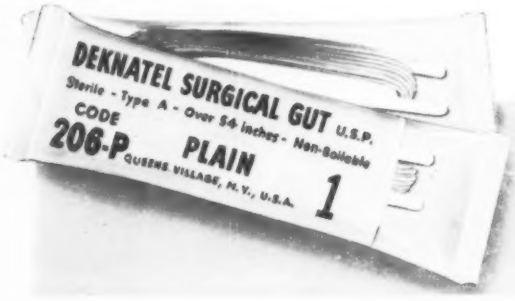
  You sterilize in formaldehyde, just as you have always done with glass tubes.

  Suture handling is reduced to the minimum as illustrated at the right.

For samples of the new Deknatel Plastic Pak, write to J. A. Deknatel & Son, Inc., Queens Village 29, New York.

Just cut straight across. Pak is transparent . . . no special care needed in cutting.

Invert the Pak. Suture slips out easily. No need to use fingers or forceps.



DEKNATEL
PLASTIC PAK
—No Glass to Break—

In Dublin, too,
Pentothal is used
almost constantly

Unmistakably

the world's

most widely studied

intravenous

anesthetic

With PENTOTHAL Sodium, there is no prolonged induction period. Recovery is smooth, rapid, because there is little drug to be detoxified. And PENTOTHAL is economical because the *total* dosage to achieve the desired levels of anesthesia is small. More than 2500 reports, covering every type of surgical procedure, have been published...over 23 years of use...where ever modern intravenous anesthesia is practiced. Abbott

PENTOTHAL® Sodium

(Thiopental Sodium for Injection, Abbott)

no pain . . .

no memory . . .

no nightmare of fear

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PENTOTHAL by rectum . . .

allows your young patients to go to sleep in the quiet of their own rooms, awaken there afterward with no memory of the events between . . . no preoperative apprehensions . . . no postoperative behavior problems.

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reduces dosage of inhalation and supplementary agents, can be used as a basal anesthetic or as a sole agent in selected minor procedures.

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a notably safe, humane approach to pediatric anesthesia.

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Here's a modern, economical ICE MAKING SYSTEM for hospitals

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ice packs
oxygen tents
bedside water
special treatments

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main kitchen
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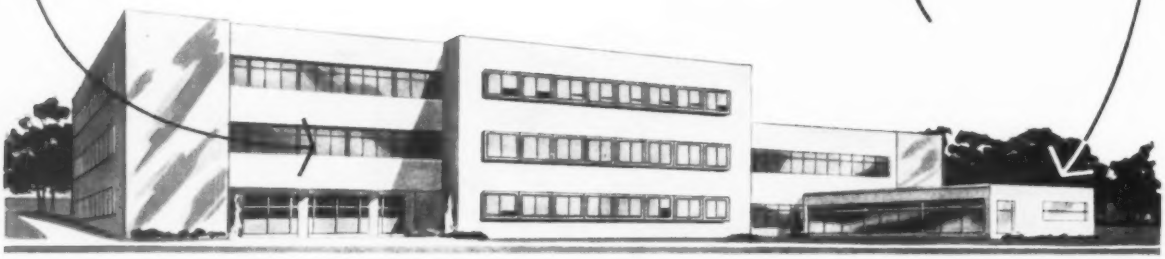


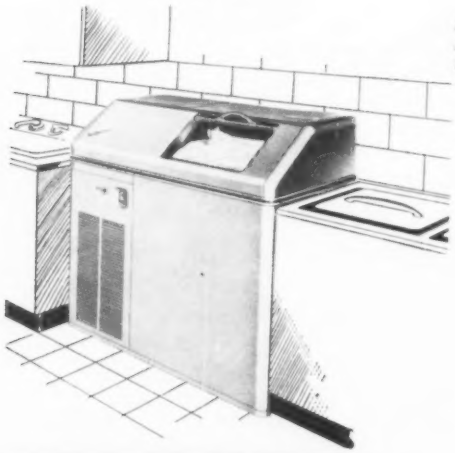
● Many leading hospitals now employ the Scotsman System for ice supply. They locate a Super Cuber or Super Flaker right where ice is needed or used.

In this way, huge, costly central ice plants are eliminated, along with their necessarily high cost of hauling ice from floor to floor. Labor is greatly reduced with the Scotsman System, and service and maintenance are far less costly.

Scotsman Automatic Ice Machines are simple to install. No special plumbing is required, and they connect easily into standard electrical outlets.

Substantial savings can be experienced with a "series" of Scotsman Machines, producing ice at point of use. And this convenience is a real time saver for your staff!

Model SF-75WSA



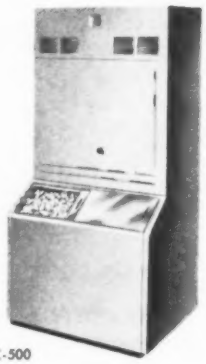
AMERICA'S ONLY COMPLETE LINE OF AUTOMATIC ICE MACHINES — SUPER CUBERS AND SUPER FLAKERS

Another outstanding advantage to the Scotsman System is that you can select a machine to meet a particular need *exactly*. No need to waste ice or overproduce.

Super Cubers make 100% pure, round, solid, crystal-clear cubes . . . daily capacities of 110 lbs., 225 lbs., and 550 lbs.

Super Flakers make the finest, most useful "crushed" ice, clear, hard and free flowing . . . daily capacities of 200 lbs., 350 lbs., 550 lbs., 1050 lbs. and 2000 lbs.

Literally, Scotsman can give you a *pound or a ton*, with maximum economy!



Model SC-500

WRITE FOR new illustrated catalogs on Super Cubers and Super Flakers. See your authorized Scotsman distributor, or write the factory. Do it today!

AMERICAN GAS MACHINE CO.

Division Queen Stove Works, Inc.
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NOW... EXPRESS

All-Purpose Liquid Cleaner

✓ CUTS COSTS
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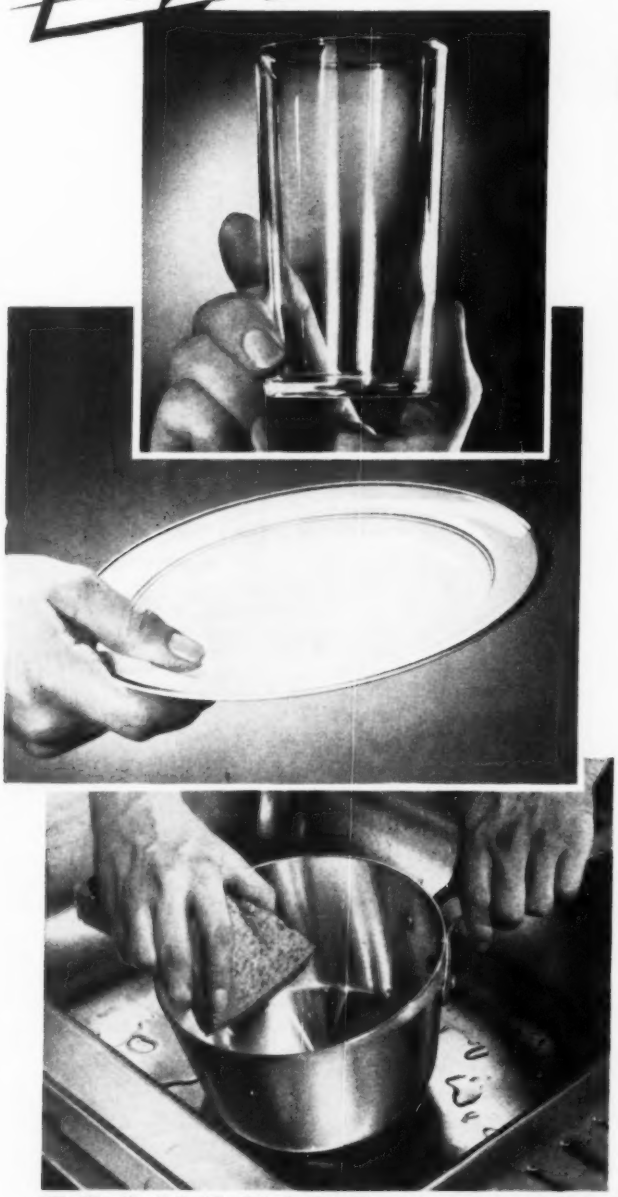

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No spotting, streaking or residue under the most difficult water conditions.

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1 oz. of Express makes up to 15 gals. of powerful long-lasting cleaning solution.

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FREE Automatic Dispenser Cuts Waste
Dispenser is supplied FREE with 1 gal., 5 gal. and 55 gal. no-return containers.

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Announcing a great new combined line ....

1D2

FAMOUS TOASTMASTER AUTOMATIC TOASTER

Makes 250 golden-good slices an hour! The toaster that has become the standard of the trade. Available in 2-slice, 4-slice, 6-8-12-16-slice combinations. Illustrated below: 8-slice Powermatic combination.

21D5D

H2512

HEAVY-DUTY SUPER G FRY KETTLE

Has uniform "All-Over" heating (heats at bottom and all 4 sides) to insure fast melting of fat without lumps. Requires only 25-28 lbs. of fat. Siphon needs no priming. Pre-heats in 4½ minutes. Auxiliary thermostat serves as constant "Fire-Gard," takes over automatically to eliminate hazard of flash fires.

CUSTOM-DESIGN COUNTER LINE

Combines "Add-On" versatility with "Perfect Profile" design. Fits 17" counter. Add matching pieces as you need them and still retain handsome all-in-one appearance. Stainless steel Counter Line includes big-capacity fry kettle; 18" and 30" griddles; food warmer; 1- and 2-unit hotplates.

N1100

POPULAR SANDWICH GRILL

Grills 9 sandwiches at a time. Exclusive "Pick-Your-Pressure" counterbalancing mechanism insures perfect grilling without crushing. Handsome design with high-polish chrome-plated exterior. Doubles as griddle.

TOASTMASTER GRISWOLD

The *complete* line of electric cooking equipment . . . for restaurant or diner . . . hotel or institution . . . kitchen or counter!

TOASTMASTER HOT-FOOD SERVER

Keeps cooked food at serving temperature for hours. Permits preparation well in advance of rush hours; immediate service without costly delays and losses. Accurate moisture and temperature control eliminates loss of flavor, texture and appetizing eye appeal of foods.

VERSATILE "SQUARE-YARD" RANGE

Many different top arrangements make this the most flexible range you can buy! Ideal for most any installation. Space-saver, too—exactly 36" square! 3 cast-iron cooking tops, accurately controlled from 250° to 850°. Heavily insulated oven. Heavy steel construction.

The "marriage" of two top-quality manufacturers of food service equipment now provides you with the finest, most complete source for your electric cooking needs. From toasters to ranges . . . fry kettles to griddles . . . Hot-Food Servers to ovens . . . Toastmaster-Griswold is the equipment you can depend on for savings when you buy . . . profits when you operate.

A seasoned expert in solving your food service problem . . . that's your Toastmaster-Griswold dealer! Let him show you how dependable Toastmaster-Griswold equipment is custom-suited to fit your specific needs. Now is the time to modernize for profits with cleaner, cooler, faster, more efficient electric cooking equipment. Go modern . . . go electric . . . with Toastmaster-Griswold!

54" COMBINATION OVENS

Two-pan size, available in 9 combinations for baking and/or roasting. Roast section has pebble steel deck to prevent burning; insures even spread of heat. Bake section has smooth one-piece core plate deck; prevents hot and cold spots. Sectional design for "Build-On" versatility. True radiant heat for perfect results every time. Also available in 36" (one-pan) size.

TOASTMASTER GRISWOLD

TOASTMASTER DIVISION • McGRAW-EDISON COMPANY

TOASTERS • BUN TOASTERS • SANDWICH GRILLS • BROILERS
FRY KETTLES • GRIDDLES • GRILLS • HOT-FOOD SERVERS • HOT PLATES
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Health-o-Meter "400"

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New—strikingly new—from the sheer lines of the base to the crisp, all new 350 lb. capacity beam and poises.

New . . . complete enclosure of all functional parts to match the modern decor of offices and examination rooms.

New, hitherto impossible long-lasting finish.

New . . . base, platform and levers permanently factory assembled to prevent disengaging at any time.

Plus engineered accuracy and dependability by Continental Scale Corporation . . . for nearly 40 years the recognized leader in the manufacture of personal weighing instruments.

SPECIFICATIONS

Color—Standard finish—oven-baked enamel. Choice of White, Beige, Mint Rose or Pearl Gray with base and platform black. Special finishes to order at extra charge.

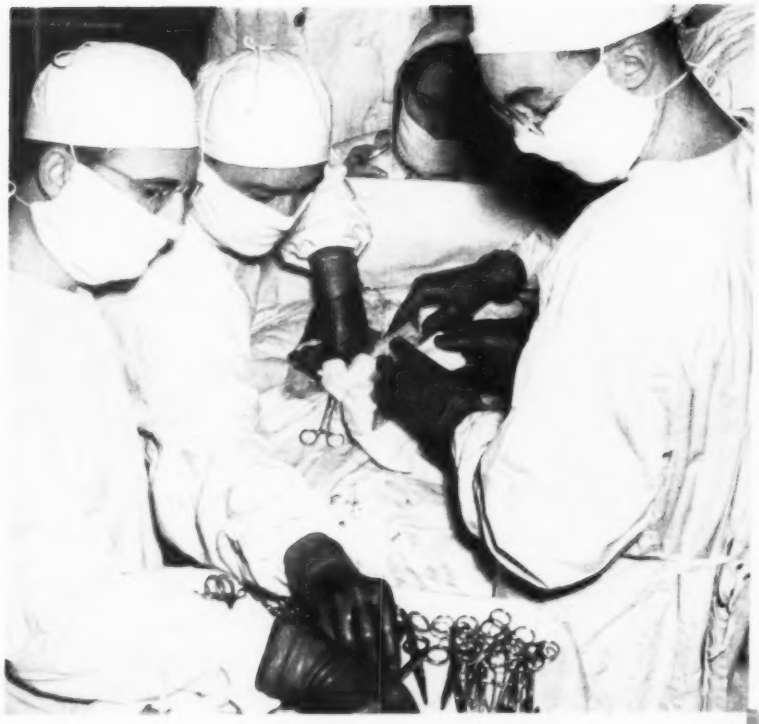
Size—Platform 10¼ x 14 inches. Space required 11 x 20 inches.

Weight—Net weight 40 lbs. Packed for shipping 55 lbs.

Capacity—350 lbs. by ¼ lbs. Measuring rod 30 to 78 inches.

Available with or without measuring rod.

CONTINENTAL SCALE CORP • 5701 S. CLAREMONT AVE. • CHICAGO 36, ILL.



one tiny spark could bring

DISASTER!...

APPLETON explosion-proof equipment gives you positive, up-to-date protection against explosion and fire hazards!

(U.L. approved for all hazardous areas in Class I, Groups C and D)

The specialized talent of APPLETON'S engineering department backed by practical experience gained in years of analyzing hospital explosion-proof requirements make APPLETON explosion-proof equipment your finest buy . . . your safest buy. There has grown around the APPLETON name, a considerable reputation in the hospital and architectural field for installations which require the barest minimum of maintenance. This factor is extremely important in that it assures you a lifetime of trouble-free operation and enables you to expand your initial purchasing estimates to include *everything you need*. Consult your electrical contractor for a safety check on your explosion-proof needs, and remember to specify APPLETON . . . the quality name in explosion-proof equipment.

X-ray film illuminators for hazardous or non-hazardous locations.

Receptacle with plug.

Two-gang Pilot Lights. Available in single gang and in combination with switch.

Two gang Switch Unlet. Single gang model also available.

Portable Current Tap with feed-in plug.

Sold Through Franchised Wholesalers Only

APPLETON ELECTRIC COMPANY *1743 Wellington Ave. · Chicago 13, Ill.*

"Our Otis ELEVATORS are
patients, staff and visitors

THE
NEW YORK POLYCLINIC
MEDICAL SCHOOL AND HOSPITAL
THE PIONEER POST-GRADUATE MEDICAL INSTITUTION IN AMERICA
Organized 1881

"We cannot overemphasize the importance of elevators in this institution," says VINCENT CARISTO, Trustee. "They're the main arteries of our building.

"You can evaluate the importance of our 4 OTIS Elevators by understanding the service they must provide. The NEW YORK POLYCLINIC Medical School and Hospital is located in the heart of New York City close to one of its most congested districts. Ours is a closed hospital. It is a school for post-graduate medical instruction and a hospital that cares for 450 patients and a very large out-patient department. We have nine operating rooms on the 10th floor.

"You can well imagine what disrupted elevator service would mean to us.

"Until three years ago we experimented with various types of elevator maintenance without success. Then we put our 4 OTIS Elevators under OTIS Maintenance. Since then we have had no difficulty. Today we are happy and proud to recommend OTIS Maintenance. It's a hospital's assurance of peak performance at all times—for just one fixed, reasonable monthly charge."

VINCENT CARISTO, *Trustee*

Otis **maintenance**
that keeps elevators running like new

ENGINEERED SERVICE BY THE MAKER

Only Otis Maintenance offers these advantages to owners of Otis Elevators

- "Engineered Service" by the maker maintains the original efficiency of the installation and assures peak performance at all times.
- Services of factory-and-field trained men with a knowledge of elevatoring that can't be matched.
- Availability of original or improved replacement parts for every installation, regardless of its age.
- Freedom from unexpected, expensive repair bills. There's just one fixed monthly charge. It can be budgeted. It's adjusted annually, up or down, on labor and material costs only. Never because of the age or condition of the equipment.
- Guarantee of the maker's high standards of safety through the constant checking and replacing of parts in advance of their breakdown point.
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- Systematic upkeep and replacement of parts extends the life of an installation indefinitely.
- The value of a maker's pride. A perfectly performing Otis installation is Otis' best salesman. That's why we're never satisfied with anything less than peak performance at all times.

OTIS ELEVATOR COMPANY • 260 ELEVENTH AVENUE • NEW YORK 1, N. Y.

the arteries that circulate the

at NEW YORK POLYCLINIC"

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The world's finest flatwork

The American Laundry Machinery Company, Cincinnati 12, Ohio

SUPER-SYLON

ironer

Unequalled in construction, performance and operation, the Super-Sylon Flatwork Ironer is another example of American's continuing advanced design. The Super-Sylon incorporates a host of outstanding features to give you finest quality ironing at highest speeds, safe, convenient operation, and added years of dependable service with less maintenance.

Here are just three of the many important ways a Super-Sylon will give you the utmost in high-quality, high-production flatwork ironing:

More years of trouble-free operation with Super-Sylon's exclusive roller-chain drive. *Separate chain drives each two rolls,* assuring positive, efficient transmission of power. No roll slippage, no wrinkling of padding. Minimum wear on roller chains and sprockets greatly reduces maintenance.

High-speed, top-quality production especially with heavy work loads, is guaranteed by Super-Sylon's close-grained, highly polished Meehanite Metal Ironing Chests. These chests, the heart and muscle of the Super-Sylon, are cast in *American's own foundry* where carefully developed casting formulas and practices are rigidly adhered to.

Even hems and embroidered areas are beautifully ironed because the Super-Sylon uses American's *exclusive* Hamilton Spring Padding. Thousands of individual conical spring coils compress one within another for greatest resiliency. Heavy spring stock lasts indefinitely. Hamilton Spring Padding will not slip, bulge or work loose, is not affected by moisture, heat or pressure—greatly reduces padding costs.

Four, six, eight and twelve-roll Super-Sylon Ironers are available to meet your specific requirements. Ask your nearby American Man from the Factory to arrange for you to inspect an American Super-Sylon in operation. See for yourself why it's the *world's finest flatwork ironer*
For additional information, write for catalog AD 565-002

You get more from

A American

"Excuse me a moment ...my pocket is paging me!"

Visitor: "Your pocket! What in the world do you mean?"

Doctor: "Didn't you hear a buzz? That was my pocket receiver telling me I'm wanted. The switchboard operator makes it sound-off by putting my own call signal on the air."

Visitor: "Sounds like a great timesaver."

Doctor: "It is! And I don't miss calls any more, no matter where I am in the building—or when I'm coming in or going out. Excuse me . . . I have to get to a phone."

A PAGEMASTER® selective radio paging system will give you instant contact with doctors and other staff personnel *throughout your entire hospital plant.*

The system includes a transmitter, which you can install in any convenient location; an encoder, about the size of a portable typewriter, located next to your receptionist or telephone switchboard; and as many transistorized pocket receivers as people who want the service.

When these people hear their own individual signals—sent out by your switchboard operator—*they simply pick up the nearest telephone and report.*

You can have a PAGEMASTER system engineered to meet your particular needs . . . give you thorough, clear coverage—whether yours is a single or multi-building operation. For full details call the PAGEMASTER distributor in your area. Or write to us at 202 Carlson Road.

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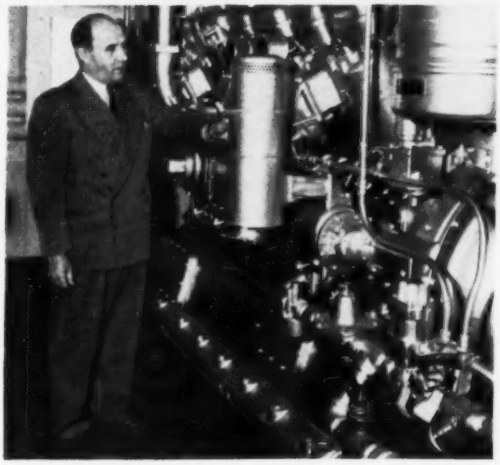
"Our hospital's CAT* D397 Electric Set starts easily and is very dependable"

William T. Guy, Plant Superintendent
Mountainside Hospital, Montclair, N. J.



To the Mountainside Hospital the installation of a Caterpillar D397 Electric Set was "a forward step in providing essential services to patients around the clock."

There's no question that emergency stand-by electric power is as essential to a hospital as the vital services it insures. Good hospital practice requires it.

Here are Mr. Guy's reasons for selecting Caterpillar power, and they come from experience. "What we like best about the Caterpillar Diesel is that it starts easily, is very dependable and is housed in a compact unit," he says. "Another important feature is its quiet operation."

Mountainside Hospital runs its D397 Electric Set occasionally at night and over week ends to supply full electric power for 8 to 10 hours at a time. "It's the best one for us," Mr. Guy says, "not too light or too heavy—and it has the ability to take an overload when necessary."

In the new line of Caterpillar Electric Sets up to 350 KW, there is one that's best for your hospital. All are available with these important features: *automatic* self-starting when regular electric power fails, *automatic* self-stopping when normal power returns. An experienced engineer is not required for supervision.

Get the complete story from your Caterpillar Dealer. He's a man you can depend on, too—for fast, efficient service and parts you can trust.

Caterpillar Tractor Co., Peoria, Illinois, U. S. A.

CATERPILLAR*

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QUARTER CENTURY OF DIESEL LEADERSHIP

Ten years ago Hartford Hospital pioneered in the use of piped medical gases for anaesthesiology. Schrader cooperated with the hospital in design and production of safety-keyed outlets. Today, this system is still operating efficiently.

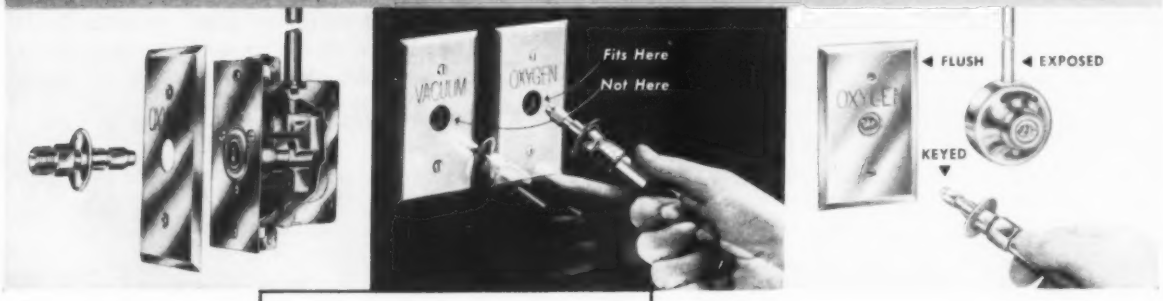
Schrader medical gas outlets have served ten years... dependably, safely, conveniently

Medical gas plug-in systems were pioneered by Schrader in cooperation with the Hartford Hospital a decade ago . . . these fittings are still in use today.

In the years since the original Hartford installation, Schrader has continued to design new and improved equipment for piping medical gases. Today, hospitals can have either Schrader safety-keyed flush-mounted or exposed outlets for oxygen, nitrous oxide, vacuum and air. You can't plug the adapter into the wrong unit. For added safety, each outlet is color keyed for the gas handled.

The new Schrader outlets can be coupled or uncoupled by a single-handed operation. Just plug in lines, or disconnect, with one motion. They're as easy to install as electric outlets. Either type will be shipped complete and ready for installation after complete inspection test. Write for further details.

LATEST SCHRADER SAFETY-KEYED OUTLETS FOR MEDICAL GAS PIPING NOW AVAILABLE



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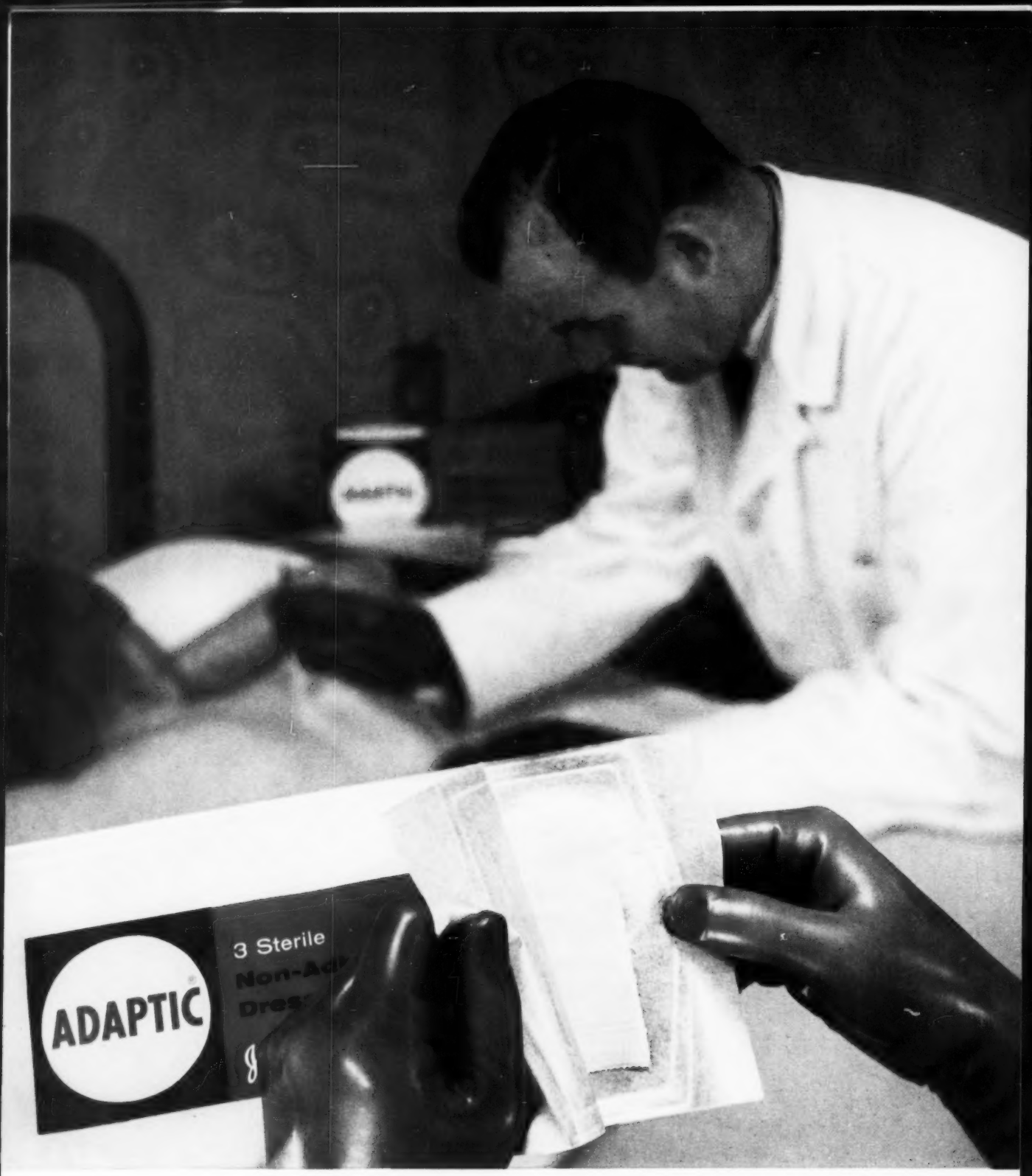
MEDICAL GAS CONTROL OUTLETS



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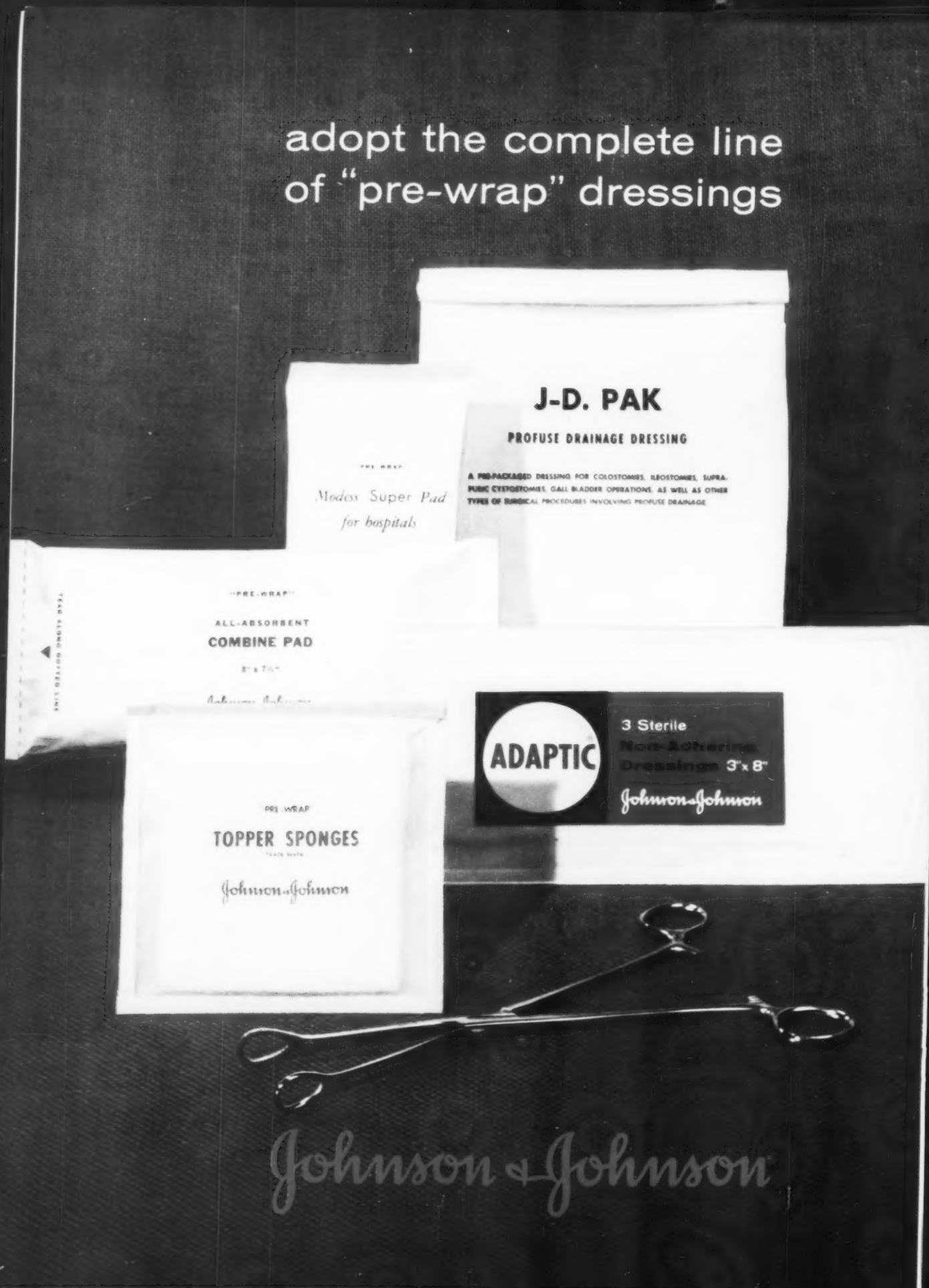

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In 1812 you might have survived an illness because of the sheer number of remedies prescribed against it. But there was no guarantee you would survive the remedies.

Luckily, diagnosis is no longer a hit-or-miss proposition. Many of today's cures start with accurate radiology. That's why so many hospital administrators order the standard prescription for radiological accuracy.
Their prescription is—Ansco X-ray Films.

Ansco X-ray Films are, of course, best known for their diagnostic readability. A readability that has grown out of this superb film's ability to separate the subtlest gradations in tissues and bone, making diagnosis an easier, surer job.
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Compare the labor, then the flavor...FREE

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No obligation, of course. Choose any of the 16 varieties listed at the bottom of this page. Compare it with the soup you are now making in your own kitchen. Let your own labor costs and your own tastes decide. Fill in the coupon and mail it for your free Chef-Size sample tin of Heinz Soup today. You'll be glad that you did.

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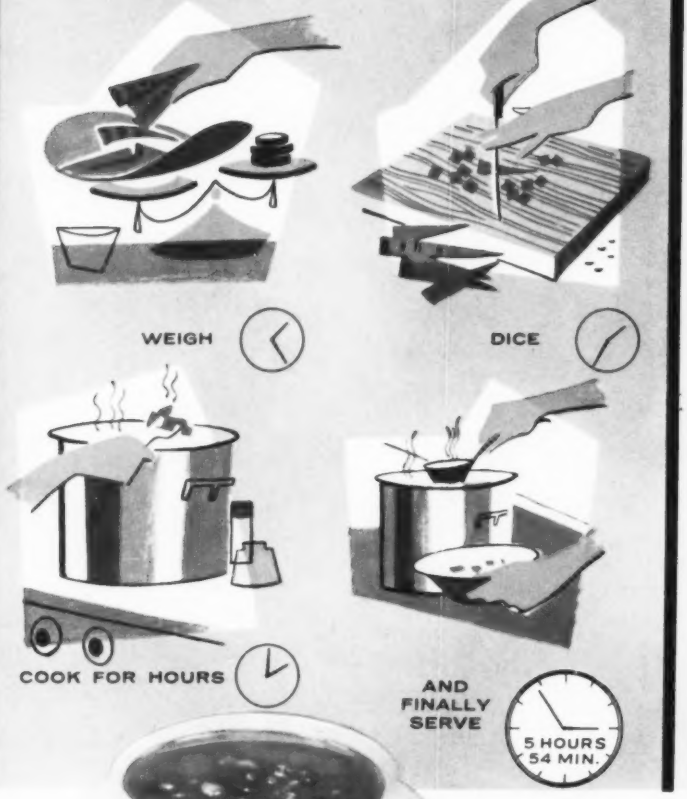
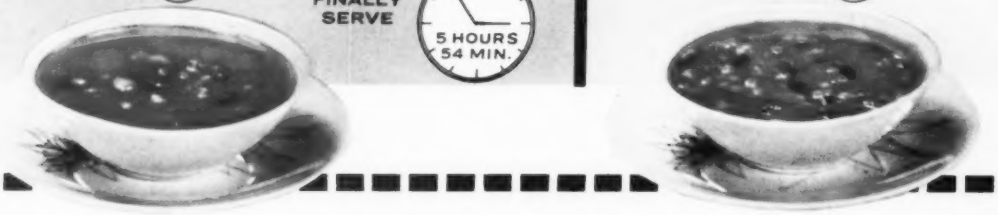
hours making soup?

SOUP AT OUR EXPENSE AND SEE!

WAY



HEINZ WAY



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Heinz 51-oz. Chef-Size Soups are condensed—one tin makes two.

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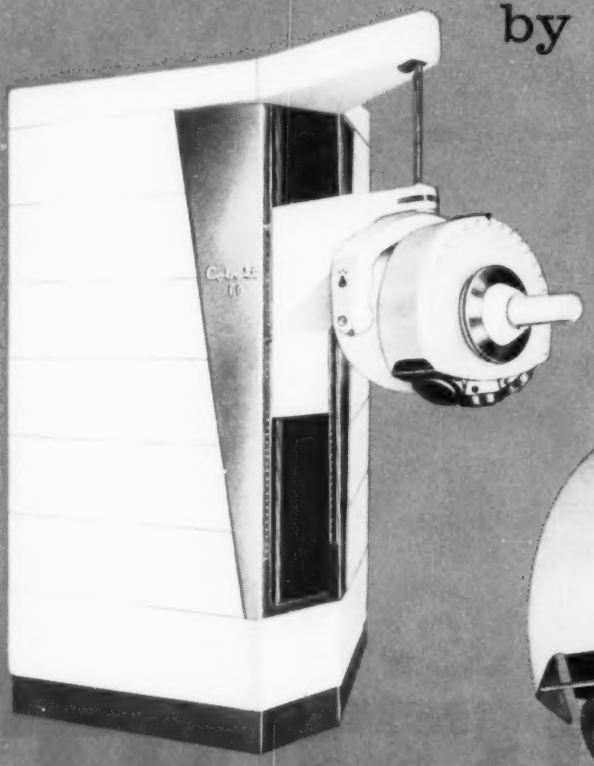
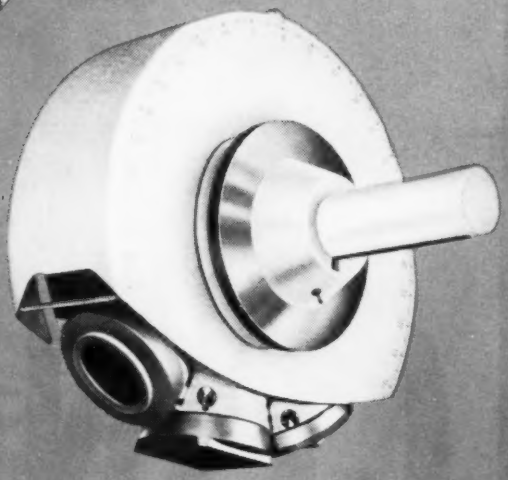
by Westinghouse



The "Dial-A-Cone" turret showing three of the six standard therapy cones. A seventh portal permits lightweight interchangeable cones.



with exclusive "dial-a-cone" turret

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Here, too, you see new *Royal* Model 2980 Universal Safety Sides that have no rods to bend, no attachment to bed-ends—there's nothing to stick or bind. Pivoted arms, when elevated to vertical, hold and lock the raised sides.

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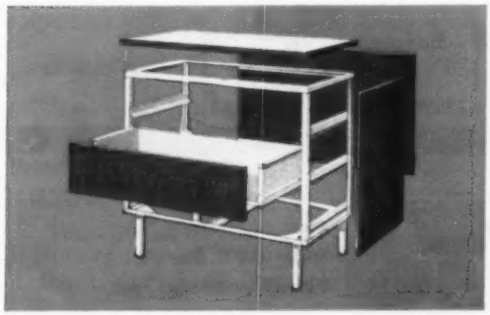

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more than other pressor drugs..."[1]

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LEVOPHED (levarterenol) given promptly raises blood pressure in seconds in surgery, hemorrhage, trauma, anesthesia.

Among 111 patients, "... 99 exhibited an appreciable increase in blood pressure ... Many had shown no response to blood transfusions alone."[2]
In another series of 75 patients in profound circulatory collapse Levophed was found most useful where the shock was due to spinal anesthesia, sympathectomy or hemorrhage during surgery. In this "most useful" group the survival rate was 94 per cent as compared to 40 per cent in the total series.[1]

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1. Eckenhoff, J. E.; and Dripps, R. D.: **Anesthesiology,** 15:681, Nov., 1954.

2. Sokoloff, Louis; King, B. D.; and Wechsler, R. L.: **Med. Clin. North America,** 38:499, Mar., 1954.

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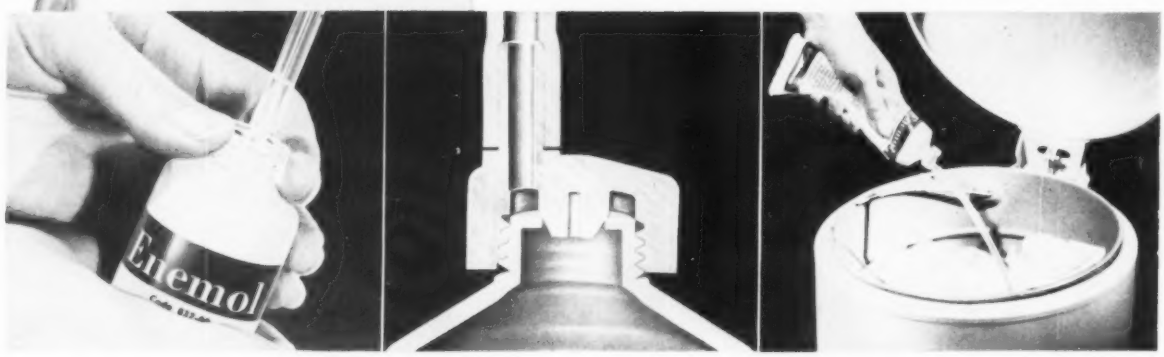
It used to be that preparing and giving those routine enemas topped my list of "Most Unpleasant Nursing Chores." But, with Enemol — it's so much easier and faster that I don't mind it nearly as much.

The thing I like best about **Enemol*** is that there's no equipment to assemble or solutions to mix. Better yet, there's no messy equipment to clean up afterwards because you just throw the used container away. That means as much as 20 minutes saved — to spend doing something else.

Enemol ***is the only disposable enema*** I know of, with a shut-off valve you can easily open and close with a simple twist. You can even clear air from the tube before inserting. The tube, with its soft round top, is just stiff and long enough (6 inches) to insert easily without hurting the patient.

Having an enema is never pleasant, but Enemol makes it a lot less uncomfortable for the patient to take. That's because there are only 4½ ounces of fluid instead of the usual quart. And for routine enemas, this time-proven phosphate solution really does a better job than soap suds.



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60 *fine pharmaceuticals for 60 years*

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PANS OUTPERFORM FOOD SERVICE TABLES

higher sustained temperatures, hold their shape, too!

Now, a new discovery in the field of heat transfer makes it possible for you to increase the efficiency of your hot food service operations, *instantly*—at a saving.

The secret is a new kind of pan—pans that look and fit like those you are now using, but with an amazing new surface that absorbs *more* heat, heats *faster* and holds *higher* temperatures.

Made from a special, hard wrought, long-lasting Wear-Ever aluminum alloy, these new pans assure *more even heating*, too. Because they s-p-r-e-a-d heat so efficiently, they entirely eliminate the problems of scorching and flavor change due to "hot spots." You can bake in them, roast in them—transfer them from oven to hot food service table or counter, ready for serving.

Better food . . . tastier . . . faster! These new Emi-Glow pans are our answer to that growing demand. We want you to try them, see how they save you time, conserve fuel, bring out the best in flavor.

Let us give you the pleasant facts on prices, too . . . in practically all sizes (with or without covers) they're *lower* than your current pans.

*A trade name, taken from the word "emissivity" . . . the ability to both transmit and absorb heat.

Foods are prepared right in Emi-Glow pan . . .

transferred in same pan to hot food service table . . .

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Gay new Springtime design makes Dixie Matched Food Service more eye and appetite appealing. Decorated in two soft colors.

Now, every item needed for hot food and beverage service is *plastic coated* by the exclusive Dixielite* process. Other cups and dishes also available in a complete range of sizes. Choose those that fit your portioning needs.

for patient peace-of-mind
...for labor-saving economy
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DIXIE

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This new sure-to-be-sanitary Dixie Food Service gives hospital patients wonderful peace of mind

It's so nice to know these special cups and plates have never been used by any other patient.

Hospital patients get a wonderful sense of security from just knowing they're the first and only ones to eat from attractive Dixie Cups and Plates. Already, this new kind of mealtime service has won the acclaim of patients and staff alike in hundreds of hospitals.

No wonder! Trays are so much lighter and easier to handle! Clean-up is a "breeze"! There's no more worry about costly breakage! The space formerly used for storing bulky crockery is released for more essential needs.

And when it comes to economy, the small per-meal cost of Dixie service is more than offset by the elimination of costly labor needed for dishwashing, stacking and carting heavy crockery to and fro.

For Complete Case-History Information about Dixie Matched Food Service as it is used by other hospitals, write:
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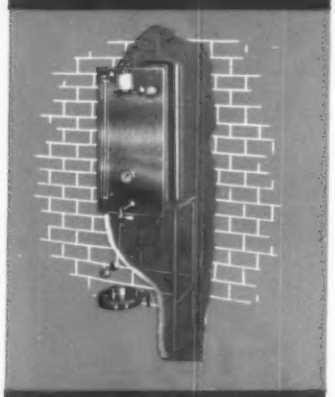

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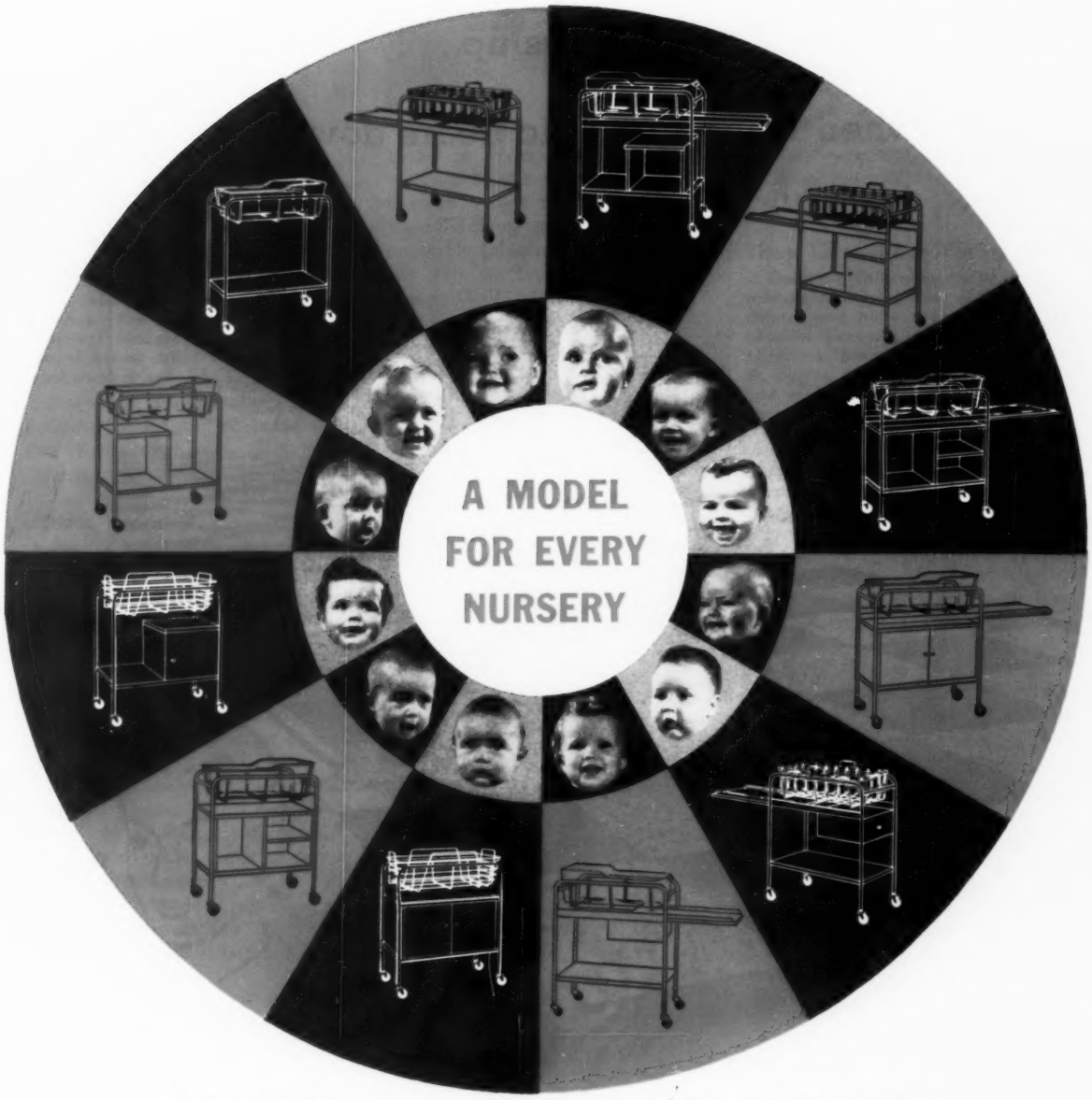

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SMALL HOSPITAL QUESTIONS

Safe Width for Corridors

Question: The main corridor on our nursing unit is only 72 inches wide, and a member of our board is concerned because of the recommendation that hospital corridors should be 8 feet wide for safety. This question has not been raised by local fire safety authorities. Are we in violation of any national building or safety code? Should this be called to the attention of local authorities?—L.C.M., Calif.

ANSWER: The newly published Building Exits Code of the National Fire Protection Association says, "Where beds are to be moved from an individual room or ward into a corridor and then turned at right angles to move along a corridor, ample corridor width is needed. A minimum of 96 inches is suggested, but in existing buildings corridors as narrow as 60 inches wide may be acceptable under some conditions. Ample space is also needed to permit making turns on stair landings where patients may have to be moved on litters or mattresses."

It seems unlikely that your 72 inch corridors violate safety standards, though they do not meet the N.F.P.A. recommended width for ease of moving beds from rooms. Certainly you should know what local regulation applies and be certain you are in conformity with the local building safety code.

Daily Report Unnecessary

Question: We have been preparing a daily report of accounts receivable for several years, so that we may know from day to day how these accounts fluctuate and thus have an estimate of our financial situation and the status of collections. This year, our auditor suggested that the daily report was not needed and these figures would be more meaningful if reported less frequently. Of course, we can save time by omitting the daily report but are reluctant to give up this close control of receivables. What is the accepted practice?—G.L.S., Ga.

ANSWER: This question was recently reviewed by a group of hospital accounting authorities who agreed that a daily report of accounts receivable had little real value as an administrative control of financial operations, because the daily fluctuations are not important. What is important, they agreed, is a monthly summary of accounts receivable, showing a balance that can be compared with the previous month's and previous year's balance, indicating the trend in accounts receivable. Of course, the report should also show the breakdown of accounts by age.

Wants Own Operating Room

Question: We have three operating rooms (two for major and one for minor surgery), and our staff performs about 900 operations a year, in a 55 bed hospital. The doctor who does the largest number of operations has been annoyed occasionally by conflicts in the operating room schedule, and he has succeeded in convincing one or two of our governing board members that he should have an operating room set aside for his own use only. We don't want to offend this doctor, but it does seem that the volume of work, though not excessive for a hospital this size, does not call for a room to be set aside for one surgeon, and it appears this would only complicate the scheduling problem. What is the practice among hospitals in this classification?—C.O.N., N.H.

ANSWER: The average 50 bed hospital includes either two or three operating rooms and performs 850 operations a year. Your schedule, while slightly more active than the average, is certainly not excessive, as you have indicated, and the number of occasions on which there could be conflict in the operating room schedules cannot be great. Thus the proposal that one of the three operating rooms be reserved exclusively for the use of a single surgeon seems unreasonable, and, unless there are reasons which are not apparent in the circumstances described here, the request should certainly be denied—for the obvious reason that it would needlessly waste facilities provided by the community and delay service to patients.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; A. A. Aita, San Antonio Community Hospital, Upland, Calif., Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

They Like Those Perquisites

Question: Following the practice recommended by lecturers at hospital institutes and authors of articles in the hospital journals, we have tried to eliminate "perquisites" for our employes, paying their entire salaries in cash and requiring them to pay for their own meals and laundry. However, nurses and other employes generally seem to prefer getting somewhat lower salaries and keeping their perquisites. What is the practice today among most hospitals? What are considered to be fair values of perquisites such as meals and laundry?—A.C.C., Wash.

ANSWER: The majority of hospitals are still providing some perquisites for at least some groups of employes, although the practice has been steadily diminishing during the last 10 years, as hospital personnel programs have become formalized. In one group of hospitals (of 100 beds and less) the value of perquisites for general staff nurses, clerks and others averaged $4.50 a month for laundry; $14 for one meal a day; $29 for two meals a day, and $43.50 for three meals a day.

How Long to Keep Tickets

Question: Would you advise how long a time we should keep the charge tickets for hospital services after they have been posted to patients' accounts? —J.C.S., Tenn.

ANSWER: This query was referred to a hospital accounting authority, who replied as follows: "Hospitals generally retain charge slips for approximately one year, or until such time as the audit for the fiscal year has been completed. The period of one year is ample to determine whether any errors have been made in posting the charges to the patients' accounts. Facilities for retaining charges are also a factor in determining how long the charge slips should be held. Triplicate copies of charge slips kept in spiral book form, for example, are generally retained for only about 30 days. These take up quite a bit of space and have served their purpose within the 30 day period. If necessary, the hospital can, even after the charge slips have been destroyed, prove the validity of charges by referring to the patients' charts."

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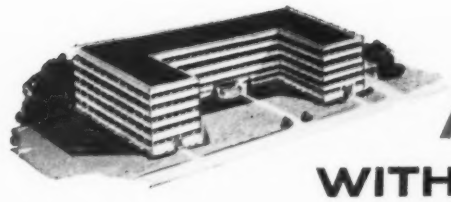

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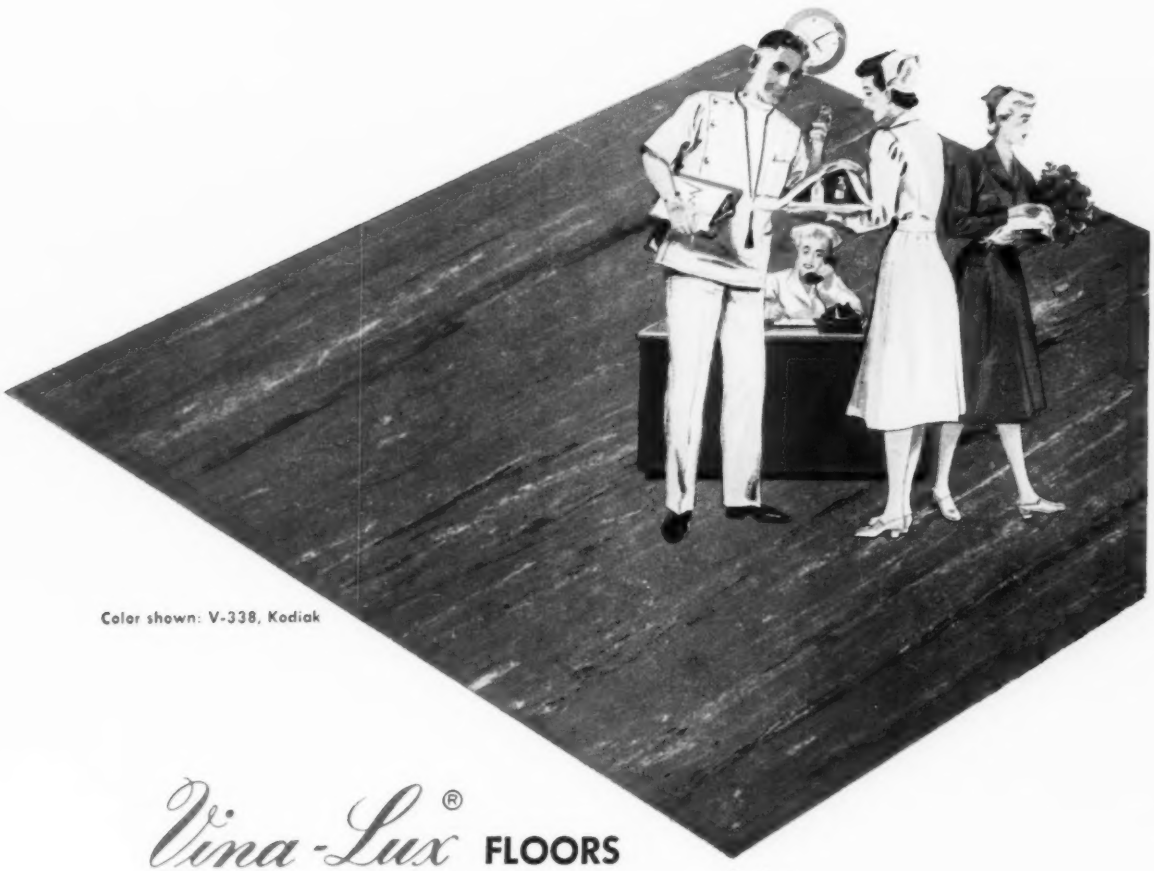
WITH CLEAN, QUIET BEAUTY



Color shown: V-338, Kodiak

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Resilient, too, Vina-Lux softens foot and wheel noises — reduces fatigue — increases safety with its slip-resistant surface. And now, with the subtle styling of *Micromatic veining*, Vina-Lux in 21 modern colors gives you a big *plus* over other resilient floorings. Samples and color chart are yours on request.

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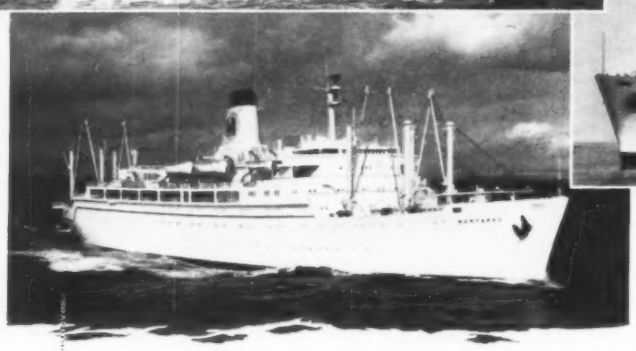

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wire from Washington

MEDICARE

A report on the first half year of Medicare shows that hospitals on the whole are cooperating fully, that costs are about the same as the normal hospital costs, and that the military officials in charge are not yet ready to recommend any major changes.

Says the report:

"It can be stated that the program has been universally accepted and somewhat widely acclaimed by civilian hospitals. . . . Many hospital officials are highly pleased with the program and the manner in which it is being administered."

The reaction is not the same with physicians. While most of them have in general accepted Medicare, the report notes that others " . . . believe that the program represents a form of socialized medicine and have brought this impression to the forefront in our negotiations and in certain articles which have been written and published."

Under Medicare (Dependents' Medical Care Program), wives and children of service personnel have a choice of medical care in military hospitals or in civilian hospitals and from civilian doctors. The dependents pay at the rate of approximately $1.75 per day.

Some other findings in the report:

Between Dec. 7, 1956, when Medicare started, and July 1, 1957, a total of 103,595 hospital claims were handled for a total payment of $10,732,272, or an average of $103.60 per hospital claim. The 127,902 physicians' claims totaled $8,805,128 for an average of $68.84.

A special study indicated the average per day hospital cost was $24.22, and the physician's per-hospital-day fee averaged $25.37. (Doctors' prehospital and posthospital costs are included in this average.)

The same study offered averages for specific treatments, including—uncomplicated maternity delivery, average of $224 and average of 4.5 hospital days; miscarriages and abortions, $155 and 2.5; complications of pregnancy, $171 and 4.5; tonsillitis, $113 and 1.4; appendicitis, $235 and 4.4.

Blue Cross and Mutual of Omaha hospital costs are keeping close together; another special study showed the Blue Cross average to be $20.86 per day (not including payments by patients), and Mutual's to be $18.78. To see if these costs were higher than the national average, Medicare compared a sampling of cases. In California, Medicare costs were found to be $30.65 per day (patients' payments included), and the average for the state $32.20; in Tennessee, Medicare costs were $22.15 and the average of all Tennessee hospital costs per day, $21.05; in Texas, $26.78 and $24.84; in Indiana, $22.83 and $22.56.

Commenting on the small margins of difference, the Medicare report says: "It would appear that the cost for dependents hospitalized under the program is in line with normal patient income (payment by or for patients) in other hospitals. . . ."

The report carries only one definite recommendation: "That the Dependents' Medical Care Program be continued as at present until studies and experience indicate that modifications are timely and appropriate."

ASIAN INFLUENZA

Although there have been only sporadic outbreaks in this country to date, U.S. Public Health Service officials stand firmly on the position they have taken since last spring on Asian influenza: The peak season for influenza has not yet arrived, and many epidemics, scattered in all areas of the country, still are more of a "probability" than a "possibility."

Meanwhile, American Hospital Association joins with P.H.S. in urging all hospital managers to make immediate arrangements for vaccinating hospital staffs. Vaccine is becoming available in increasing amounts, and with their high priority rating hospital personnel should be able to obtain the necessary vaccine.

It is emphasized that hospital staffs, along with other health personnel, are in the first priority in the recommendations of P.H.S., which are being adopted by most communities. After health personnel, the next in line are those furnishing essential services, such as police and firemen.

Other developments:

1. **Vaccine is being allocated** voluntarily by the six producers, with each state's share based on its population.

2. **While production is running** far ahead of first estimates, there won't be enough for the entire population until well after the normal influenza epidemic season has arrived.

3. **Through formal and informal meetings** and a volume of correspondence, American Hospital Association and other medical groups are taking the lead in preparing the defenses against the new flu.

4. **For hospital people** interested in a complete run-down on both public health and scientific aspects of Asian flu, Public Health Service will furnish at no cost the transcript of proceedings of the special meeting of state and territorial health officers in Washington, attended also by representatives of A.H.A.

5. **Medicare has announced** that while Asian flu vaccinations will be given to dependents in military hospitals,

vaccinations are not authorized at government expense in civilian hospitals.

I.R.S. RULES ON "RELATED SERVICES"

Some hospitals that perform medically related services, for a fee, for outside organizations or institutions are concerned with a recent ruling of the Internal Revenue Service. Attention to the following points in the ruling may clarify their own particular situation:

A foundation organized and operated to conduct and support scientific research was itself exempt from federal taxation. However, it was engaged in large-scale related businesses, the operation of a photographic and illustrative service and an electroencephalography clinic, both used extensively by outside institutions. Three-fourths of the foundation's income was from these outside fees.

In its ruling, I.R.S. dwelt heavily on the fact that while the services might be "related," the income they produced was disproportionate to the size and extent of the foundation's other activities, whose tax-exempt status was not questioned.

The ruling says in part that the secondary activity loses its tax-exempt status "if the income . . . is disproportionate . . . or if its primary purpose is the production of income, or if it is operated in the same manner as a commercial business. . . ."

The implication is that nominal income from a related activity would not disqualify that activity.

In rulings on other cases in hospital fields, the Internal Revenue Service:

Decided that money received by interns and residents performing services at a medical training hospital, in order to complete or receive specialized training, is compensation for services rendered and must be regarded as taxable. Said I.R.S.: "The interns and residents . . . are primarily performing services for the hospital as physicians, even though, in the process, they are acquiring training and experience in their particular specialties. . . . The stipends received . . . represent compensation for services and do not constitute scholarships or fellowship grants," which would be excludable.

Decided the same way regarding hospital money paid to student employes who were serving one year at the hospital as administrative residents as a condition to receiving the degree of master of hospital administration from a university. ". . . Since the salary, the amount of which is at the discretion of the hospital, was paid by the hospital for services rendered, it does not qualify as a scholarship or fellowship grant . . . and is includable in gross income. . . ."

But I.R.S. held that university students enrolled in advanced courses for professional nurses under Public Health Service grants need not pay income tax on the grant money.

CIVIL DEFENSE PROBLEM

A problem is developing over an offer of Federal Civil Defense Administration to pay half the cost of stand-by generators for possible use of hospitals in time of disaster.

Until last January, no hospitals located in a target area were eligible for the extra power plants, and there were other restrictions that discouraged most hospitals.

In January, the regulations were liberalized, perhaps to too great an extent. Hospitals in a target area, but no other institutions, were authorized to receive federal grants for the power plants, and the generators could be large enough to supply up to 80 per cent of the hospital's normal daily needs.

Then the trouble started. Several hospitals applied for grants to help them buy generators capable of putting out as much as 750 kilowatts, and others were ready to take advantage of the bargain. What was happening, or could happen, was obvious to F.C.D.A. Once in possession of new power plants for "emergencies," hospitals would be under great temptation to make use of them and save their old equipment for the emergencies. Also, hospitals might be sold more electrical capacity than they would need or could afford.

The whole situation was gone over frankly at a conference attended by representatives of A.H.A., Public Health Service, the military departments, and F.C.D.A. Recommended changes were drafted, but not announced, pending more complete study by the organizations. The possibility, however, is that the limit will be put at 30 or 40 per cent of normal needs rather than 80 per cent, with a few exceptions to be allowed. Some of the larger type generators cost more than $100,000.

COMMUNICATIONS

A committee of the American Hospital Association is moving ahead vigorously to ensure that radio channels will be set aside for the use of hospitals. A.H.A. has hired special counsel in Washington to draft a petition to the Federal Communications Commission for filing before an October 3 deadline set by F.C.C.

At a meeting of the A.H.A. group with representatives of the American Medical Association, the electronics industry and the Federal Trade Commission, some of the problems were discussed, and there was every indication from the F.C.C. spokesmen that the petition would be considered sympathetically.

A.M.A. also expects to file a similar petition for channels for doctors.

If granted, the channels would be a fast and sure means of communication among doctors and hospitals under normal conditions as well as a highly valuable network for use in an emergency when phones might be knocked out or overloaded. The channels also could be used for medical educational purposes.

STUDY P.H.S. HOSPITALS

A significant cost study is under way within the Public Health Service, which has the primary responsibility for the medical care of 265,000 persons and responsibility for treating on-the-job injuries of another million—the latter U.S. employes and employes of U.S. contractors who are under workmen's compensation.

The Budget Bureau has instructed the P.H.S. to make a study of four of its general hospitals—Chicago, Detroit, Memphis, Tenn., and Savannah, Ga.—to learn if the patients could get good medical care at less cost in near-by military or civilian hospitals.

If it is found that money could be saved by closing the P.H.S. hospitals, there is no doubt the bureau would demand that action. Also, conceivably this approach might be considered for the eight other P.H.S. general hospitals, which are not included in the present survey.

Packing the aisles of what was said to be the largest display ever assembled in Atlantic City's huge Convention Hall, hospital people saw the emerging shape of industry's answers to the ever-present scarcity of hospital personnel: automation and disposability

The Modern Hospital

OCTOBER 1957

LOOKING AROUND THE 1957 CONVENTION

Papa's Job

ATLANTIC CITY, N.J., OCT. 3—Titillated by anticipation of a contest that was ruled illegal before the bell rang for the first round, the 59th annual convention of the American Hospital Association here this week kept more than 11,000 men and women occupied for four days with assemblies, conferences, panel discussions and round tables, and an accompanying merry-go-round of breakfasts, luncheons, teas, receptions and dinners. Altogether, the calendar of convention events numbered some 200 separate occasions on which people gathered together to talk about hospitals—not counting the times when they assembled in smaller rooms for other purposes and hospital talk was inevitable, if not compulsory.

Sooner or later at those times, talk turned to the A.H.A. presidential nomination, which was widely expected, for the first time in 20 years, to result in a contested election on the floor of the House of Delegates—an expectation that fizzled out when the nominating committee presented Ray Amberg of Minnesota as its candidate and, in an accompanying statement, asked members not to give the committee a hard time any more by beating the drums for particular candidates. "Endorsements . . . should not be politically inspired but should represent the thoughtful and considered opinions of persons sufficiently well informed as to permit careful evaluation of the endorsed individual's qualifications," said the committee. Possibly interpreting this to mean "Papa knows best," the drum-beaters subsided, and there were no nominations from the floor.

NEW OFFICERS

PRESIDENT-ELECT: Ray M. Amberg, director, University of Minnesota Hospitals, Minneapolis.

TREASURER: John N. Hatfield, director, Passavant Memorial Hospital, Chicago.

BOARD OF TRUSTEES (New Members): R. Adm. Bartholomew W. Hogan, M.C., USN, Chief, Bureau of Medicine and Surgery, Department of Navy, Washington, D.C.; Rt. Rev. Msgr. Edmund J. Goebel, director of hospitals, Archdiocese of Milwaukee, Milwaukee, and Carl C. Lamley, executive director, Stormont-Vail Hospital, Topeka, Kan.

DELEGATES-AT-LARGE: Donald W. Cordes, administrator, Iowa Methodist Hospital, Des Moines; Msgr. Robert A. Maher, diocesan director, Catholic Hospitals, Toledo; Dr. Lucius R. Wilson, director, Episcopal Hospital, Philadelphia, and Clarence E. Wonnacott, administrator, Latter-Day Saints Hospital, Salt Lake City, Utah.

TO FILL UNEXPIRED TERMS: Hal G. Perrin, administrator, Bishop Clarkson Memorial Hospital, Omaha, Neb.; Dr. Roy A. Wolford, deputy chief medical director, Veterans Administration, Washington, D. C.

In general assemblies and at formal banquets, the convention heard speakers from other disciplines praise the Lord and renounce sin with a wide variety of oratorical skills, including one who belted it out like Billy Graham with benzedrine, and another who went on and on until dignitaries at the head table started making book on how long he would last. In their own panels and round tables, however, hospital people got down to business and dealt realistically with such hard facts of hospital life as dirty floors, cheap dollars, vanishing nurses, and doctors who act like doctors. In the round tables, especially, expanded this year to cover 66 separate subjects, audiences and panels exchanged information and ideas about hospital practice, finding a few answers, and more problems than they knew they had, and, as always, gaining at least that amount of courage that comes with the knowl-

BUTTONHOLE INTERVIEWS

Should there be open campaigning for A.H.A. offices?

DR. A. W. SNOKE, *president, American Hospital Association, and adm., Grace-New Haven Community Hospital, New Haven, Conn.:* I think it is awfully embarrassing for the man being campaigned for. JOHN HAYES, *former A.H.A. president, New York City:* I agree that it puts a great deal of pressure on the person who is the candidate for office.

OLIVER G. PRATT, *dir., Rhode Island Hosp., Providence:* It is important for the president-elect to have a solid background of experience serving on the board of trustees or in the House of Delegates. JOSEPH G. NORBY, *consultant, Milwaukee:* I object to campaigns, because I believe the nominating procedure represents the composite voice of the A.H.A.

RICHARD D. VANDERWARKER, *gen. mgr., Memorial Center, New York City:* It seems to me it is democratic. It shows growth in the organization that there is enough interest to draw competition. TOL TERRELL, *Texas, A.H.A. president-elect:* I would defer to the judgment of the nominating committee.

edge that even the worst of problems is shared by others.

Marching the endless aisles of the glittering exhibition hall, hospital administrators could see the steadily emerging shape of industry's answers to the everlasting labor shortage: automation and disposability. In what was reportedly the largest display ever assembled in Atlantic City's Convention Hall, they could see a measure of the importance of hospitals in our society, and in newspaper headlines during the convention, they saw another measure: the Ford Foundation's $825,000 gift to the American Hospital Association. If there are some who grow restive occasionally when the "Papa knows best" type of rule is in evidence, nobody can deny that Papa does a hell of a job.

Saving Paper

MEETING in scheduled sessions Monday, Tuesday and Wednesday mornings of convention week, the American Hospital Association's House of Delegates put its stamp of approval on the work of the association's board of trustees, councils and committees. This year, the House used a new kind of stamp—a system of review committees designed to give members an opportunity to discuss the annual reports of the councils before they were presented to the House for action. The system worked moderately well, with a few members showing up at each of nine review committee meetings to debate their recommendations with council members and staff. The major difficulty—lack of attendance at the meetings—was attributed to the fact that the decision to use the committees was made too late to publicize the method in advance of the convention.

For the most part, the members and delegates who did come to the meetings had something to say. Among others, Delegate Clyde Fox of Nevada said something about A.H.A. proposals for federal aid to nursing education, and Delegate George Wood of California said something about the proposal for extension of the Hill-Burton Act with provision of grants for renovation and modernization.

They both said phooey. Specifically, Delegate Fox said: "We talk about the growing expense of government, but we still go to the government for everything. If hospitals can't take care of their own needs these days, God help us when we have a depression."

Added Delegate Wood: "Hill-Burton was an emergency measure, and the emergency is over. We should stand on our own feet and take no government handouts."

When both propositions reached the floor of the House on Wednesday, only Delegate Fox' voice was heard in protest, and only Delegate Fox voted no. Delegate Wood had left the convention. Without opposition, the House approved the proposals to seek a five-year extension of Hill-Burton, addition of the renovation and modernization grants, no change in the basic Hill-Burton formula, continued support of the Blue Cross formula in Medicare, and aid to nursing education.

In another review committee, members of the Council on Professional Practice and a few visitors considered what might be done with government aid for nursing education if it should be forthcoming. The accreditation program for nursing schools took a mild shellacking, but, again, when the professional practice report, including a proposal to expand the A.H.A.'s nursing staff, went to the House, only Delegate Thomas Hale of New York, a man who is standing pat where nursing education used to be, could be heard pleading for A.H.A. to "be the champion of the three-year schools of nursing in hospitals."

The review committee that was meeting with the board of trustees took up a delicate subject and heard some cheering news: So far, only 26 institutions have resigned from A.H.A. as a result of the dues-building hassle last spring, and it was suggested that a little missionary work might still bring some of the lost souls back to the altar. Only two large hospitals were among the apostates, it was reported. States with the largest number of resignations were, in order: Minnesota, Nebraska, Texas, West Virginia and Virginia. Summarizing the damage, Chairman John N. Hatfield of the special board committee on building was conservative when he said the A.H.A. had "come out of it pretty well, considering the amount of emotionalism generated by the building program."

In the House of Delegates, Mr. Hatfield reported on the building program and Tol Terrell of Texas, incoming president, reported for the special committee on fund raising, which recommended that fund raising for the association be limited to seeking support for special projects "from philanthropic

and other sources." The John Price Jones survey of A.H.A.'s fund-raising moxie, which was estimated to be low, cost $30,000, Mr. Terrell said. Nobody asked any questions.

When all the councils, and all the review committees, had been heard from, Past President Ray E. Brown of Chicago, who presided at sessions of the House, judged the committee system a success. "It worked smoothly, considering this was our first effort," he said. "It will have most meaning when the membership learns to participate. The committees can become a source of ideas for program development."

If the committee system fell a little short of expectations in introducing critical observations in the House of Delegates, there was one reliable critic on hand, ready as always to apply astringents as needed—Retiring President Albert W. Snoke. In a "state of the nation" report to the House, Dr. Snoke warned that "our voluntary system is on trial—and we do not have forever to satisfy public demands."

Blue Shield must catch up with Blue Cross if public demands for comprehensive prepaid medical and hospital care are to be answered by the voluntary method, Dr. Snoke stated. "I would hope that organized medicine at all levels would assume greater initiative and responsibility in recognizing the problems involved in the financing and payment for voluntary hospital care and medical care in these days of social change," he said, jabbing the needle in at a familiar site. "I suggest that hospitals and physicians stop debating over the wording of suggested financial contracts between hospital-medical specialists and hospitals, or over the nonsense that hospital administrators are trying to take over the practice of medicine, and direct our mutual attention to areas that are vital to our future."

Concluding its 1957 business with the election of officers, the House of Delegates administered a sharp rebuke to those who have been conducting open campaigns for A.H.A. office, and those who think such campaigns are appropriate, when it unanimously approved, by separate resolution, a "Guide to the Standing Committee on Nominations," introduced by Ritz E. Heerman of Los Angeles, chairman of the committee.

"The committee is alarmed about the increasing tendency to inaugurate organized campaigns for candidates for the office of the president-elect," this said. "Such campaigns cannot take into consideration the points enumerated above." These points were:

1. Officers, trustees and delegates-at-large should be representative geographically, and by size and type of hospital, of association membership.

2. Candidates for president-elect should be outstanding hospital administrators with records of diligent association service on committees and councils, and as trustees.

3. Trustee candidates should be leaders in state and regional associations, with presidential possibilities.

For a few years, at any rate, it seemed likely there would be no more organized campaigns for office within the American Hospital Association, which may now be the only organization of comparable size in the world with an official ban on "politically inspired letters"—to use the language of the resolution. It should save a lot of paper.

It Worked for Us

WELL, sometimes it worked and sometimes it didn't. Many of the projects reported in the three sessions devoted to "It Worked for Us," a new series of meetings featured at this convention, have been highly successful; others apparently haven't.

One of the most useful, particularly to small hospitals that complain they "can't afford" a public relations program, was reported in the Wednesday morning session by S. Lucille Whitty of Wilmington, N.C. Mrs. Whitty is secretary to the administrator of Community Hospital, Wilmington, and for the last year has also served as public relations officer. The hospital is operated by the city and the county, and suffers from many handicaps, but it has taken as its theme "Every Day Is Hospital Day at Community" and is vigorously promoting good relations with employes, staff, patients and the surrounding community—at virtually no cost.

Ray M. Amberg, President-Elect

For example, the weekly employe meetings, which used to be haphazard affairs with no particular purpose, have been converted into a continuing inservice training program for employes. Patients are made to feel like guests. Each one is visited when he is admitted and asked if he wishes to see his pastor; during his stay, he is visited by the administrator or Mrs. Whitty to be sure that he is being well treated, and at the time of discharge, he is interviewed again and asked to state his views on the hospital and make any recommendations for improvements.

At a cost of 47 cents a month, the hospital issues a house organ to its 125 staff members, filled with news and editorials to keep them aware of the hospital's policies and problems.

Outside the hospital, Mrs. Whitty has discovered that press, radio, television and numerous health organizations are happy to give free aid and publicity to a worthy cause, such as Community Hospital. The local school cooperates by making its library facilities available to hospital personnel and sends students to the hospital for educational tours. Not long ago, the hospital put on a television show that was directed, shot and edited by hospital people telling the hospital's story to the area served by the TV station. The total cost was around $6—the price of the film.

Rewards from the public relations program have been astonishing, said Mrs. Whitty, including such tangible ones as $30,000 from the city of Wilmington to decrease the accounts payable, larger appropriations from the county board "because they have become more aware of the needs," and many small contributions and gifts up to $200.

Other successful projects included the supervisory training program at Sharon General Hospital, Sharon, Pa., and an inservice education course for head nurses at Children's Orthopedic Hospital, Seattle.

One project that bit back was reported by Robert S. Hoyt, administrator of Lutheran Hospital of Maryland, Baltimore. Carried away by the

success of a reorganization plan for the hospital's laundry, which had been in a bad way, the administration went on to do a bit of streamlining and reorganizing in other areas. It got into trouble with the reorganization of the housekeeping setup, Mr. Hoyt explained, through being too hasty. When nursing complained that housekeeping routines upset the nursing program, a review of the situation led to the firing of the executive housekeeper and her two assistants and a reassignment of "housekeeping floor teams" to be directed by the nursing staff.

The theory behind all this was to eliminate the "constant coming and going" of housekeeping personnel in patient areas and also to schedule the work around nursing needs. Furthermore, someone decided that the noise of the buffing machines was a nuisance to patients and it would be better all around to use a floor preparation that would keep the floors shiny without benefit of wax, which has to be buffed. It appeared that these procedures should logically result in cutting the staff. So they cut the staff from 43 to 29 and eliminated wax on the floors. Unfortunately, Mr. Hoyt pointed out, floors seem to need wax in order to be properly maintained, so they are now being waxed—and buffed. However, the wax presently used requires buffing only once a week, which is a gain. Also, the manpower cut was too drastic, hospital authorities finally decided. You can't maintain a hospital properly without people. The maintenance staff is now back up to 35—still a gain.

The real cause of woe to the administration, according to the speaker, was the speed with which the changes were put into effect. "We should have taken time to educate personnel before we did it," said Mr. Hoyt. "We upset the morale of some employes and damaged the esprit de corps of the hospital." His parting words to the audience were: "Anyone who contemplates streamlining the organization to cut costs should move slowly and carry a big bottle of aspirin."

GOOD PATIENT CARE

Austin J. Evans, administrator of Hadley Memorial Hospital, Hays, Kan., candidly informed the Thursday morning audience that his subject "Good Patient Care Is the Primary Goal of Good Administration," is "so elementary it is almost trite." And yet, he said, the program committee thought it should be restated at this meeting.

What has, in most instances at least, worked at Hadley Memorial is the determination to do whatever needs to be done to give the patients the best care—and find the money for it somehow. He cited as an example the installation of a recovery room which the hospital frankly couldn't afford. But staff and patients wanted it and so it was installed. Thus far, the recovery room has saved four lives and has made hundreds of patients more comfortable and helped them get well quicker. Hence, the board feels amply repaid for the financial finagling it had to go through to pay for the unit.

Sometimes, a service that has been instituted primarily for the welfare of patients offers a cash reward. Such a case at Hadley has been the radioisotope unit set up at the request of the radiologist. It draws patients from a wide area and is now paying its own way.

The hospital has its failures, too, Mr. Evans reported, even though its motives are of the highest. Because the radiologist was giving such fine consultation service to a large section of Western Kansas, the hospital trustees thought they should offer a similar service in pathology. They hired a pathologist, installed a well equipped tissue laboratory, and found a qualified technician to do the work—and the whole project fell flat. There was no rapport between pathologist and staff and the "patient service was actually worse than it had been when we were sending tissues miles away for diagnosis," Mr. Evans explained. However, he is not discouraged. Some day Hadley will have a new pathologist.

TRUSTEES

What worked for Nahman Schochet, attorney and chairman of the board of Itasca County Hospital, Grand Rapids, Minn., was an impartial survey of the hospital made by an outside consultant which showed up some very peculiar goings-on. However, the burden of Mr. Schochet's talk was not so much what the survey did and how it was done, but why it had to be done. He was a man with a complaint to make and he made it: that whatever trustees manage to learn about the hospitals for which they are responsible, they learn the hard way. Nobody gives the new board member any real training for his job. He may be a whiz as a banker, lawyer, merchant or chief—but that's not much help in understanding a hospital. It is Mr. Schochet's conviction that no longer should a prospective trustee be allowed to accept the job without some training for it.

What usually happens, the speaker said, is that the new board member is taken on a quick tour of the hospital, introduced to hordes of people whose names he never catches, fed in the hospital cafeteria, and maybe gets his picture in the employes' bulletin. What should happen, Mr. Schochet feels, is that the new trustee is given a sound orientation to the institution, its history and policies, and basic courses of a practical nature. These should include local rules and regulations that affect the hospital, good public relations, cooperation between board and staff, and to what extent the board must rely on the administrator for guidance. At this point the speaker threw an acid crack at administrators who evade trustees' questions with the admonition: "You mustn't ask that; we have to do it because of our accreditation—or because the American Hospital Association says thus and so." He calls this practice putting an iron curtain between the administrator and the board.

The survey of Itasca County Hospital which Mr. Schochet discussed was undertaken just because the trustees had been kept ignorant of the actual operation of the hospital. It was extremely successful, but he still thinks there are easier ways for a trustee to learn about his hospital.

DEPRECIATION

After a five-minute recitation of the degrees, honors and committee appointments possessed by Paul J. Spencer of Jamaica Plain, Mass., the earnest lady chairman concluded by saying he is "a board of directors—." He is also a one-man campaign for funding depreciation. By funding, Mr. Spencer doesn't mean one of those mythical "book" transactions. He means actually depositing money in an account on which checks can be drawn to pay for capital equipment. To Mr. Spencer's way of thinking, this practice not only provides peace of mind for the administrator and gives him a comfortable reserve of ready cash when he is faced with a big expenditure, it is the only honest way to operate. Furthermore, he believes that in future third-party payers are going to insist

that the payments they make toward depreciation to replace capital items must be funded.

The speaker also pointed out that hospitals can't keep going to the public for money and certainly not for "prosaic paraphernalia" like floor coverings and light fixtures. But these things have to be replaced and the money for them must be found somewhere. Mr. Spencer finds it in his depreciation fund.

Federal Hospitals

A LESS urbane and well adjusted man than Maj. Gen. Howard McC. Snyder, personal physician to President Eisenhower, would probably have stomped angrily out of the Federal Hospital luncheon on Tuesday and strangled with her own telephone cords the hotel switchboard operator who, with fiendish persistence, rang a phone in the meeting room throughout almost all of his talk to the 630 assembled guests. The guests were ready to do it for him, but the General raised neither his bushy silver eyebrows nor his gentle voice as he reviewed the progress of hospitals and the practice of medicine during his "seven-odd" decades of existence.

Those who had come to hear a verbal dissection of the internal economy of the President of the United States were sadly disappointed. The speaker never mentioned his eminent employer. Instead, he held forth on the importance of sound construction of hospital buildings, with the emphasis on the need for cheerful and handsome architecture; the astounding improvements in professional services "both within and without the hospital" since his own early days in medicine, and the qualities of leadership and judgment needed by hospital administrators which, the speaker pointed out, are reflected not only within the hospital walls but in community relations.

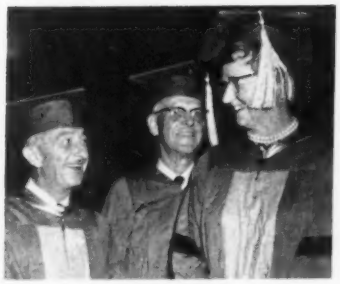
In the same mellifluous accents with which he commended hospitals for their accomplishments, General Snyder urged them to "correct many faults which still challenge your endeavors." Some corrections he would like to see include "prevention of the breakdown between the operating room and the pathology department"; "prevention of overloaded laboratories through careless practices"; "prevention of impersonal care of patients," and "prevention of rising costs" which, he contends, the public is viewing with increasing alarm.

BUTTONHOLE INTERVIEWS

Can hospitals use industrial management methods?

CARL A. LAMLEY, *adm., Stormont-Vail Hosp., Topeka, Kan.:* There is a general impression that hospitals have to be inefficient. That is not true. There is hardly any operation in the hospital that hasn't been carefully preplanned. COL. FREDERICK H. GIBBS *(U.S. Army, ret.), dir., V.A. Institute for Hospital Administrators, Washington, D.C.:* They not only can but they are using them. A good example is the time-motion studies that have been made of x-ray scheduling and equipment layout.

Do you think the public appreciates hospitals?



A. A. AITA, *adm., San Antonio Com. Hosp., Upland, Calif.:* Yes. Our community looks on the hospital as the place to turn to. Strangely enough, I don't think the public even feels overcharged. DR. LUCIUS W. JOHNSON, *San Diego, Calif.:* Those of the public who have been in hospitals do appreciate them. Those who have never been in hospitals have some very twisted ideas. ELMINA L. SNOW, *adm., Emerson Hospital, Concord, Mass.:* Yes. They show appreciation by doing work and raising funds.

Round Tables

FAME and fortune await the clairvoyant who can tell program planners exactly how many people will show up at a given session. The clairvoyant had not been found in time for the A.H.A. convention, although the planners were able to call their shots pretty closely in setting up space for such round table discussions as nursing and accreditation. Wisely, they gave them room—and lots of it. Room was needed because they were the two subjects of overpowering interest to the delegates, judging by both meeting attendance and corridor conversations. Dr. Kenneth Babcock, director of the Joint Commission on Accreditation of Hospitals, mentioned that it took him 30 minutes to progress from one end of the exhibition hall to the other because so many people wanted "just a word" with him.

In some other sessions, the planners didn't guess the space needs quite so closely. For instance, a handful of physical therapists strained to hear speakers in an echoing room that looked and sounded like an empty swimming pool, while across the hall eager attendants at the session on health needs for the aged snuggled as closely as possible to one another, perched on radiators and window sills, and wrapped themselves around the door jamb.

What they were trying to hear were the views expressed by a panel consisting of J. Douglas Colman, vice president and secretary of the Blue Cross Association; Nelson H. Cruikshank, director, department of social security, A.F.L.-C.I.O.; Prof. Carl H. Fischer, school of business administration, University of Michigan, and Dr. G. Halsey Hunt, director, Center for Aging Research, Institutes of Health, Public Health Service. Mr. Cruikshank and Prof. Fischer took opposite sides on the issue of whether the Forand Bill, providing free hospitalization for covered men over 65, women over 62, and surviving widows and children, was a sound answer to the problem of protecting the health of this increasingly large segment of the population. Mr. Cruikshank, who discussed the bill in detail, is in favor of it. To Prof. Fischer "the government is our last resort" in this area. He is holding out for voluntary insurance to find a way to provide the answer. The recommendation by the panel moderator, Dr. James P. Dixon, Philadelphia Commissioner of Public Health, that "the social principle deserved careful study" probably didn't change their minds a bit.

NURSES

The nurse educators and one of their most articulate opponents, Dr. Thomas Hale, Jr., Albany Hospital, Albany, N.Y., came face to face on the

BUTTONHOLE INTERVIEWS

Is the nursing shortage getting worse?

DR. HAROLD COON, *adm., Milwaukee County Hospitals:* It is not so much a shortage of nurses as an increased demand for their services. STANLEY A. FERGUSON, *adm., University Hosps., Cleveland:* There will never be enough nurses; we will always find new places to use them. Hospitals will have to train additional personnel to perform some nursing duties.

Are doctor-hospital relations getting better?

DR. A. J. J. ROURKE, *hosp. consult., New York:* They are vastly improved. The joint conference committee has done more than anything else to bring about understanding. DR. KENNETH B. BABCOCK, *dir. Jt. Com. Accrdt.:* I agree with Dr. Rourke. The Stover committee report of the A.M.A. has had a great deal to do with the improvement.

DON W. CORDES, *adm., Iowa Methodist Hospital, Des Moines:* Yes. I believe the solution lies in making the profession dignified enough to attract men. The stigma that formerly attached to male nurses is rapidly disappearing in our area. JOHN N. HATFIELD, *adm., Passavant Memorial Hospital, Chicago:* Yes, it is, and do you want to know the remedy? It is to pay nursing personnel adequate salaries, salaries that are commensurate with their professional status.

PAUL J. SPENCER, *adm., Faulkner Hospital, Jamaica Plain, Mass.:* I know of only one bad situation in my area. LOUIS BLAIR, *St. Luke's Methodist Hosp., Cedar Rapids, Iowa:* Much better since medical society and hospital association discussed the problem. The era of court action is behind us. DR. DAVID B. WILSON, *dir., Univ. of Miss. Medical Ctr., Jackson:* We have pretty well worked out our problems through an informal liaison group working with hospital and medical associations for good relations.

platform of a round table session on the patterns of nursing education. The nurses out-articulated him. An imposing array of nursing talent confronted Dr. Hale and his fellow "reaction panelist," (that's how they were listed) Dr. T. Stewart Hamilton, executive director of Hartford Hospital, Hartford, Conn. Dr. Hamilton looked as if he were having a good time, but the same could not be said for Dr. Hale.

The nursing panel on Monday afternoon included Ruth Kuehn, dean of the school of nursing, University of Pittsburgh; Florence Flores, director of nursing, Massachusetts Memorial Hospital, Boston; Neva Stevenson, practical nursing consultant, National League for Nursing, Inc., New York, and Mildred Montag, associate professor of nursing education, Columbia University. Each of the group discussed one level of nursing education: Miss Kuehn, the degree course; Miss Flores, the three-year diploma course; Mrs. Stevenson, the practical nurse course, and Miss Montag, the new two-year junior college course.

Possibly because of Miss Montag's enthusiasm for her subject, most of the discussion centered on the junior college course. She was kept busy explaining that the two-year course is not just a condensed three-year course and that it is built around the college, not the hospital. The hospitals are used as laboratories, she explained. The students do render some service to patients while they are in the hospitals but that is not their primary purpose for being there. One-third of the subjects offered are in the humanities, the other two-thirds are in nursing. Subjects are grouped broadly so that like things are taught together. Students progress from the normal to the abnormal situation, *i.e.* they learn first about well people and then about sick ones.

One question that seemed to exercise quite a few members of the audience was whether a nurse who started in a two-year course, for example, and wanted to go on and take a higher degree could do so. They also wondered if some practical nurses who discovered they had real talent for nursing could progress to a higher status by taking additional courses or whether each course was self-limiting. It was explained that arrangements could be made to apply partial credit from the one or two-year courses on the higher levels.

Management

"THIS is all very good, but just where do I apply it in my situation?" was a reaction expressed by panelists at the first two symposiums on management.

The speeches which brought out the reaction were given Monday by Kenneth McFarland, Ph.D., educational consultant and lecturer for General Motors Corporation, and on Tuesday by David G. Moore, professor of management, College of Business and Public Service, Michigan State University.

"Hospital employes should act toward patients as you would if you were welcoming your sister's boy friend into your own home," was one conclusion of Mr. McFarland's largely inspirational talk. The speaker was unable to stay long enough to discuss the panel's reaction to his remarks.

Reporting on a study of reasons for failure, Mr. McFarland noted that the vast majority of persons studied had been fired for reasons having nothing to do with their on-the-job skill. The reasons he listed included: intemperance, disloyalty, laziness, poor health, and poor personality.

"Statistics is the art and science of reaching decisions from data," Dean W. Allen Wallis of the University of

Chicago School of Business told the third of the management symposiums Wednesday afternoon.

Most statistical studies today involve taking a sampling from a large body of data. If the sampling must be done on a large scale in order to be of any value the cost involved may be more than the results would be worth.

The strategic decision involves determining what figures are wanted. The dean's example was cost per patient days. He queried: Is this what is desired or would the proportion of cost to the number of patient days be more useful? Or would the proportion of occupied bed days to number of occupiable beds be the best?

This must be determined by the administrator, Mr. Wallis pointed out.

Asked how a hospital administrator could get help in statistics, Mr. Wallis suggested that he get a working knowledge of statistics; he use university statisticians if available; he hire a statistical consultant, or that his trade association hire a statistician.

"Whatever you do you'll be sorry," said Richard D. Vanderwarker, vice president and general manager of New York's Memorial Center for Cancer and Allied Diseases, at the Thursday symposium.

"But decision making is the principal function of the executive," he continued.

He defined decision making as selecting one action from a number of courses of action.

The decisions come in two varieties: the tactical and the strategic. The first involves day-to-day problems and the second is concerned with broad policy.

The elements in decision making include: defining the problem, analyzing the problem, developing alternatives, selecting the solution, and making the decision effective by getting acceptance for it.

In winning acceptance for a decision a major consideration is the problem of loyalty groups. Every administrator faces this problem and must evolve a method for working it out.

General Assemblies

A CONCERN with the fact that our ethical values are failing to keep pace with scientific advances was expressed by two of the speakers at the general assemblies conducted twice daily at Convention Hall ballroom.

The fears were expressed by President Carter Davidson of Union College, Schenectady, N.Y., and Ralph W. Sockman, D.D., minister of Christ Church Methodist and the National Radio Pulpit.

In other assemblies:

A review of the medical field over the last 30 years and a forecast for the next 30 years was made by Dr. Julian P. Price, a member of the board of the American Medical Association and chairman of the board of commissioners of the Joint Commission on Accreditation of Hospitals.

Gov. Robert B. Meyner of New Jersey discussed his public relations program using "Accountability" as his theme.

Rep. John E. Fogarty of Rhode Island cited the need for a comprehensive one-package health insurance policy.

Basil O'Connor, president of the National Foundation for Infantile Paralysis, Inc., emphasized a point made also by Rep. Fogarty, that nursing home facilities are a major need in the immediate future.

Mr. Davidson predicted that the number of student nurses will double by 1970.

Owing to the expense involved, however, Mr. Davidson doubted that the number of medical school graduates will increase at all. Places in medical schools will become even more prized, and the hospital seeking interns must strive even harder to maintain a good educational program.

"One of our mutual responsibilities is that of accountability," Gov. Meyner told the Tuesday morning general assembly.

"We are accountable for the use we make of resources and monies entrusted to our administration. If we are to do effectively the things we consider essential, we must inform those from whom we seek support," the governor continued.

Accomplishing this is made difficult because of the tremendous competition for people's attention, he noted.

Recommendations adaptable to the hospital field included: an open door policy for the press, a plan for communicating with the press on a regularly scheduled basis, frankness, willingness to meet the public by accepting speech invitations, and simplicity of expression in talking or writing.

"We may be bemused by the Madison Avenue Myth into thinking of public relations as an exotic science. The matter of fact is that there is no substitute in public relations for old-fashioned Main Street simplicity, honesty and candor," Gov. Meyner concluded.

Dr. Price predicted for the next 30 years that: Communicable diseases will be eradicated; virus diseases will increase; degenerative disease will be of greater concern; specialization will continue; more hospitals will be located in the suburbs and smaller communities, and strenuous efforts to pass a federally controlled medical health system will fail.

Faced with the ability to commit race suicide, man must match his knowledge with a sense of values, according to Dr. Sockman. "We must develop our mental health to match our physical health," the clergyman said.

Despite the fact that church attendance is at an all-time high, he continued, the crime rate also sets new records.

As physical living becomes increasingly easy in today's world, Dr. Sockman said, it becomes more and more difficult for man to maintain a moral standard.

The test of a man's morals is his behavior in the dark, and our urban style of living, with its emphasis on anonymity, puts modern man increasingly to the test.

"However, I have faith that God wouldn't let man near the matchbox unless the framework was fireproof," Dr. Sockman related.

PREVENTIVE CARE

A prediction that every hospital in the nation will be providing at least as much preventive care as curative service was made Wednesday afternoon by Rep. Fogarty.

This was one of a number of health needs for the future discussed by the congressman from Rhode Island.

Expanded facilities in general hospitals for outpatient departments, rehabilitation facilities, and areas for the chronically ill were other needs discussed by Rep. Fogarty.

"Nursing homes provide a good example. I was shocked, as I know you were, to learn that nursing homes have been declared at the top of the list of unsafe places to live," continued the congressman.

Attention being given problems created by rising costs were also considered by Mr. Fogarty. He listed irksome turnover in lower paid jobs, the constant need for more nurses, and the ever present threat of a deficit and cited work being done under the Hill-

Burton Act and in the Public Health Service to alleviate these problems.

In the field of insurance he particularly stressed the need for protection against catastrophic illness.

Only one-half of the needed nursing home beds are available today, Mr. O'Connor said, and only one-half of these are considered acceptable by today's standards.

"Frankly, it is difficult for the lay mind to understand why our community hospitals have not done more to help solve this universal problem," said Mr. O'Connor.

Auxiliaries

ISN'T it a privilege," exclaimed the chairman of one of the auxiliary sessions, "to be a group of women who are so creative and doing such wonderful things!" Several hundred heads bobbed an energetic affirmative in a room so tightly packed with creative auxiliaries that there was scarcely room for bobbing.

From Park Avenue to Paragould, Ark., and points between and beyond, it is apparent, there is no let-up in the number and variety of ideas being generated by auxiliary members for the benefit of their respective hospitals.

Three of them were presented at the Tuesday morning Parade of Projects. Leading the parade was Mrs. Walter Hochschild of New York City who explained the Art for Hospitals project of the United Hospital Fund of New York. Operating on the thesis that art has therapeutic value for sick people, the committee of which Mrs. Hochschild is chairman started in 1951 to introduce art into hospitals. First, a letter was sent out to a list of 8000 art-minded people requesting donations of pictures. What the committee wanted was cheerful, happy pictures—no abstracts, no black and whites, no controversial subjects, no nudes. It took time, Mrs. Hochschild reported, but they began to come in—and then go out to hospitals and convalescent homes. To date, the committee has given 1250 pictures to 61 voluntary and municipal hospitals and 11 affiliated convalescent homes.

A new "member" of the auxiliary was introduced next on the program. She turned out to be Pe-Te (standing for physical therapy) who owes her existence to the cooperative efforts of Margaret Prior, director of physical therapy at Kenosha Hospital, Kenosha, Wis., and the hospital's auxiliary. Miss Prior had the idea for Pe-Te when she was trying to think up ways of making the retraining of damaged arm and hand muscles less tedious for her patients. She mentioned her idea to Mrs. Joseph E. Stein of the Kenosha auxiliary—and Pe-Te was born. She is an out-size doll for which members have designed and made various articles of clothing provided with all the difficult contrivances invented by clothing manufacturers to make getting dressed a problem for people with damaged muscles. While Miss Prior spoke and showed slides, Mrs. Stein dressed Pe-Te, and from the gurgles of admiration during the demonstration it seemed clear that department stores all over the country are about to enjoy a boom in doll sales, while the auxiliaries get busy with the sewing machines.

The final project of the Tuesday series, amusingly related by Mrs. Rufus D. Haynes, president of the auxiliary of Community Methodist Hospital, Paragould, Ark., appealed especially to members from smaller communities. To lure citizens of the area served by the Paragould hospital into using the institution, Mrs. Haynes explained, the auxiliary hit upon the plan of offering free blood-typing service to people attending the 1956 county fair. So successful was this public relations project, she reported, that of 3500 paid admissions 620 visited the booth to be typed. Furthermore, a large number were enrolled in the hospital's blood donor service.

College

Anthony W. Eckert of Perth Amboy, N.J., was named president-elect of the American College of Hospital Administrators during the business session of the College's 23d annual meeting Monday.

Dr. Albert G. Hahn of Evansville, Ind., was elected first vice president, and A. A. Aita of Upland, Calif., is the new second vice president.

In other events, the College installed a large group of candidates at the annual convocation in the ballroom Sunday afternoon, designated four new honorary fellows, conducted the annual banquet, heard the Bachmeyer Lecture, and dispatched the College's business in a routine fashion.

President A. J. Swanson reported that 340 were received as nominees of the College at the Sunday convocation, 238 were advanced to membership, and 97 were made fellows of the College.

Those receiving honorary fellowships were: Msgr. John G. Fullerton, director of Catholic Charities in Toronto, Ont.; Dr. Lucius W. Johnson of San Diego, Calif.; Lucile Petry Leone, chief nurse officer, Public Health Service, Washington, D.C., and Dr. William S. Middleton, medical director, Veterans Administration, Washington, D.C.

Six persons were honored at the annual banquet. J. Dewey Lutes, the immediate past president, was given the president's emblem, and testimonials were presented to Dr. T. Stewart Hamilton, Anthony W. Eckert, David A. Endres, Ray M. Amberg, and A. A. Aita, all retiring members of the board of regents.

In delivering the Bachmeyer Lecture Sunday evening, Elmore Petersen, dean emeritus of the University of Colorado School of Business, recommended a practical code for administration. It would have three criteria: The philosophy must be consistent with the recognized principles of organization and management; it must be such that it is the dominating influence in shaping the policies and achieving the objectives of the enterprise, and it must be recognized that the philosophy of administration tends to conform to the personal philosophy of the administrator.

"In a world where hospitals are pricing themselves out of the ability of the patient to pay, the importance of a group such as this becomes even greater," President Swanson told the College at the Monday business session.

He announced that the College has a grant from the Kellogg Foundation for publication of case reports; that the first session of the 25th anniversary observance, set for February 1958, will consider the subject "Administration as a Science," and that Ray E. Brown is chairman of a committee to consider holding the College conventions apart from the A.H.A. meeting.

The College heard reports from the study committee on admissions, the insurance committee, the educational policies committee, the committee on institutes, the code of ethics committee, and the by-laws committee.

New regents elected are: R. W. Bachmeyer, director, St. Barnabas Hospital, Minneapolis; Wilson L. Benfer, superintendent, Toledo Hospital, Toledo, Ohio; Alfred E. Maffly, administrator, Herrick Memorial Hospital, Berkeley, Calif., and Leo G. Schmelzer, director, Wilmington General Hospital, Wilmington, Del.

THE PERSONALITY OF AN ADMINISTRATOR

The good administrator must be impartial, basing his decisions on facts rather than personalities. He must build up the quality of good judgment. A ready supply of that none too plentiful quality—courage—is needed. All this must be tempered with kindness, and a sense of humor is invaluable, according to S. G. Hill, secretary of the Northampton, England, District Hospital Management Committee, and also past president of the Institute of Hospital Administrators. This distinguished Englishman has produced, in the opinion of the editors, an unusually thoughtful appraisal of the qualities of character and conduct called for in hospital administration.

S. G. HILL

AN ADMINISTRATOR requires two qualifications: knowledge of the job, and the right type of personality.

There are those who go so far as to hold that knowledge of the job is not strictly necessary, and that a person who can administer one thing with success can administer something else with equal success. I do not go anything like as far as that. I do, however, regard the personal aspect of administration as of extreme importance and the theory that this is all that is necessary, while much too exaggerated, does at least act as a corrective against the counter theory which holds that all that matters is the extent of a person's knowledge of a job and tends to ignore the importance of personal attributes.

Can an administrative personality be acquired? I think the answer is a qualified Yes.

SOME ARE BORN

We may accept that, at the one extreme, there are people to whom administration will come easily because they are born with the sort of temperament that most readily leads to administrative success. It is much the same thing as some people having a definite gift for dealing with figures, while others have a strong sense of direction, and yet others have a naturally artistic outlook. Those fellows who have what I might call an administrative temperament are the ones who achieve and deserve success in administrative posts. At the other extreme, there are, I think, without question, some people whose temperament is such that they will never be successful administrators however well qualified they may be in the technical requirements of the job. I do not even know if such people exist in senior administrative posts because theoretically, and probably also in practice, they tend to seek other outlets for their abilities when they find that they cannot make a success of minor and intermediate administrative jobs.

These, however, are the extremes. In between, there are hundreds, perhaps thousands, of ordinary people with neither any brilliant gift nor any serious temperamental handicap, and it is my belief that people in this wide category can do much to develop the sort of personality which helps them to become successful administrators.

THE QUALITY OF IMPARTIALITY

As a first personal attribute of any administrator, I would put the quality of impartiality. Much of administration comprises deciding between competing issues, frequently represented by conflicting people, and although an administrator may decide rightly or wrongly, it is of first line importance that he should be unbiased and impartial and should base his decision entirely upon the facts and merits of the case and not upon his view of the personalities involved. I am not visualizing only a big dispute between important people, but the hundreds of day-to-day matters which an administrator has to deal with, many of them not in the form of momentous decisions. It should never be assumed of an administrator that he will tend to agree with Mr. A. or Dr. B. no matter what the issue may be. Neither should it be assumed that Miss X is more likely to receive favourable consideration to an extra hour off duty than Mr. Y.

All this is a great deal more difficult than it may sound. We are all human and it is only natural that of the people with whom we work, some commend themselves to us more than others. However much we may flatter ourselves upon our impartiality, we are probably not quite as impartial as we think we are, and however hard we try, we will be lucky if we escape the reputation of having a soft spot for Miss X or of being in Dr. Z's pocket. But we must keep trying because this is among the most important personal attributes of administration and, in particular, we must guard against the flatteries of powerful people if these are likely to influence our impartiality.

GOOD JUDGMENT

Next as a quality I would place judgment. A lot of the time an administrator has to decide what to do

(*Continued on Page* 59)

This article is an abridged version of an address delivered at a conference of the Institute of Hospital Administrators at Winchester, England.

HOW TO MAKE SEVEN EMPLOYES DO THE WORK OF ONE

ADMINISTRATORS have assumed that a rising total in the number of employes of a hospital must reflect a growing volume of work to be done. The fact is that the number of employes and the quantity of work to be done are not related to each other at all. The rise in the total of employes is governed by a mathematical formula and would be much the same whether the volume of work were to increase, diminish or even disappear.

There are two conditions which underlie the general tendency to which this formula gives definition. *Condition 1:* An administrator wants to multiply subordinates, not rivals. *Condition 2:* Administrators make work for one another. To comprehend Condition 1 we must picture a department head called "A" who finds himself overworked. Whether this overwork is real or imaginary is immaterial, but we should observe in passing that A's sensation or illusion might easily result from his own decreasing energy, which is a normal symptom of middle age. For this real or imagined overwork there are, broadly speaking, three possible remedies: 1. He may resign. 2. He may ask to share the work with a colleague whom we shall call "B." 3. He may demand the assistance of subordinates to be called "C" and "D."

THEY ALL CHOOSE THE THIRD

There is no recorded instance in the entire history of hospitals of A choosing any but the third alternative. By resignation he would lose his pension rights, should there be any, and by having B appointed on his own level in the hierarchy, he would merely bring in a rival for promotion to W's vacancy when W retires.

So A would rather have C or D, junior men, below him who will add to his importance and be dividing the work into two categories as between C and D. A will have this merit of being the only man who comprehends them both. It is essential to realize at this point that C and D are, as it were, inseparable. To appoint C alone would have been impossible because C, if by himself, would divide the work with A and so assume almost equal status which has been refused in the first instance to B—a status the more emphasized if C is A's only possible successor.

When C complains in turn of being overworked, as he certainly will, A will have the concurrence of C to advise the appointment of two assistants to help C, but he can then avert internal friction only by devising the appointment of two or more assistants to help D whose position is much the same. With this addition of G and H, the promotion of A is now virtually assured.

Seven people are now doing what one did before, and this is where Condition 2 comes into operation. These seven men make so much work for one another that all are fully occupied, and A is actually working harder than ever before. An incoming letter may well come for each of them in turn. E decides that it falls within the province of F. F places a draft reply before C, who amends it drastically before consulting D, who asks G to deal with it. G goes on vacation at this point and hands the file over to H, who drafts a memorandum which is signed by D and returned to C, who revises his draft accordingly and lays the new version before A.

What does A do? He would have every excuse for signing the thing unread for he has many other matters on his mind. He knows now that he is to succeed W next year, and he has to decide whether C or D should succeed to his own office. He had to agree to G going on vacation, although not yet strictly entitled to it. He is worried whether H should not have gone instead, for reasons of health. H has looked pale recently partly, but not solely, because of domestic troubles. Then there is the business of F's increase in salary for special work he has been doing, and E has an application for transfer to another department.

A has also heard that D is in love with a typist in the admission office and that G and F are no longer on speaking terms. No one seems to know why. So A might be tempted to sign C's draft and be done with it. But A is a conscientious man. Beset as he is with problems created by his colleagues for themselves and for him, created by the mere fact of these officials' existence, he is not the man to shirk his duty.

He reads through the draft with care, deletes the fussy paragraphs added by C and H, and restores the thing to the form preferred in the first instance by the able, if quarrelsome, F. He corrects the English—none of these young men can write grammatically — and finally produces the same reply he would have written if officials C to H had never been born.

Far more people have taken far longer to produce the same result. No one has been idle. All have done their best. It is late in the evening before A finally quits his office. The last of the office lights are being turned off in the gathering dusk which marks the end of another day's administrative toil. Among the last to leave, A reflects with bowed shoulders and a wry smile that late hours, like gray hairs, are among the penalties of success.

—JOHN GORBY.

(*Continued From Page 57*)

and, once again, these are not a series of momentous decisions but the sort of thing that makes up our day's work: Shall we write a friendly letter or a rather firm one; shall we report a certain item to the board now or leave it to see what develops by next month; shall we report it in writing or verbally; shall we make much of it or little; shall we mention certain opinions and make certain suggestions or shall we confine ourselves entirely to the facts as they exist?

Now it is no use saying there is a formula for dealing with all this. Sometimes you do report a matter at once, sometimes you leave it. Sometimes you do confine yourself to facts, other times you express opinions and forecasts. All these things are matters of judgment according to the exact circumstances of the particular case. Judgment, by which I mean, of course, good judgment, is broadly inherent, but it can be very much developed by experience. Acute observation and analysis, attributes which should be available to all, are the main factors involved. Notice what happens with regard to actions taken either by yourself or by your immediate superiors. Analyze the outcome of the action and see how it is related to the action taken.

IT IS QUITE SIMPLE

All this sounds very complicated, but really it is quite simple. Just see how people do things and how things work out. That is observation. The analysis part is necessary to make sure that you are accurately relating cause and effect. You might, for example, deal with a given matter in a certain way on a Friday and a certain result would ensue, but that result might have nothing to do with the fact that you took the action on a Friday. On the other hand, it might have: It could be connected with something that only happens on a Friday, such as payday or fish for lunch. Judgment is built up, often quite unconsciously, from a series of experiences, but the analysis must accompany the observation. You learn by experience only if you are yourself absolutely clear as to what particular experience is involved at the particular time. If you observe your immediate superior adopt an aggressive and high-handed attitude in dismissing an Irish laborer and you note that he collects a thick ear for his pains, you will presumably be cautious when it is your turn to dismiss an Irish laborer, but you should extend this caution also to the dismissal of an English laborer, as similar considerations may apply.

COURAGE

Next, I think I would put courage—a none too plentiful commodity. Administration involves for a depressing proportion of its time the unpleasant task of giving decisions and taking actions which are unpalatable to someone. Of course, if the someone involved is a junior member of the staff, or patients or visitors, we do not need to call very much upon our reserves of courage, but if the aggrieved party is someone of rather greater importance, then courage is involved, and I refer to moral courage, which some regard as being scarcer than physical courage.

Nobody particularly relishes these moments; it is not too wise to make enemies in high places, and public life tends here and there to attract people who seek domination for its own sake and who do not readily brook opposition. Nevertheless, there are certain rules, disciplines of temperament if you like, which are helpful in such cases.

First, you must be sure of your facts, and this includes being satisfied that there is no compromise or middle way or concession which can reasonably be made. Herein lies your judgment. Second, your case must be honest as well as efficient. There must be no dark corners of personal bias which are there to be discovered if one digs deeply enough. In other words, you must be truly impartial. Third, you must handle the situation with tact and courtesy and with no thought of driving home any advantage because your case is strong, and certainly in no spirit of satisfaction in your successful challenge of power and authority. If all these conditions exist, then grasp the nettle and you will be surprised how little it stings.

Fairness based upon judgment, honesty and reasonableness can never be gainsaid, and all the tactful diplomatic evasions and circumlocutions of unpalatable matters do little more than postpone the inevitable reckoning which becomes even more unpleasant as efforts are made to postpone or escape it.

The people who get involved in real difficulties are precisely those who by a series of evasions, shifts and dubious devices of one sort or another are constantly seeking to run away from unpalatable issues. So courage is not only a necessary and useful quality in an administrator, it is, in fact, one which will save him a great deal of time and anxiety.

KINDNESS

Combined with fairness and good judgment must be what I can only describe in general terms as humanity. The quality of skill in personal relationships is based very largely upon the quality of impartiality which I have already mentioned. It does, however, go beyond it. One could be completely unbiased and impartial and yet not a skillful person in handling people. You might tend to question whether kindness has any place in the equipment of an administrator, admirable as it is in a person. I claim, however, that it is a very useful part of administrative personal relationships. Bearing in mind that one of an administrator's jobs is to induce people to give the best service of which they are capable, it is valid to enquire by what method he shall set about this. Broadly he has two alternatives. He can exact service by fear or by kindness. Leaving aside purely moral considerations, I hold the view that kindness, consideration and a readiness to give and take, on the whole bring forth service more appropriate to a hospital service than do rigid discipline and the fear that if you do not measure up, you will be sacked. By kindness I do not, of course, mean slackness, and every organization must operate upon a basis of routine and there must be rules which are to be observed. Some organizations cannot be efficiently run except upon a basis of rigid discipline, most obvious examples being the armed services, but I feel that a kindly and understanding and cooperative attitude on the part of the administrator is not only more appropriate to the hospital field, but it does in the long run give more efficient service, though there will always be those who will take advantage of what appears to them to be slackness.

A genuine interest in human beings is really part of the kindness, and it is mentioned because it is doubtful if there can be a real effective kindness without an interest in human beings. By interest I do not mean nosiness or preoccupation with the private affairs of one's colleagues and officers, but an appreciation of their attitude and reaction to events. No man who is not

interested in human nature can realize what pain he is giving to a sensitive officer whom he blames for some error without taking the trouble to see if blame really lies with that officer. Such a man would not, perhaps, mean to be unkind, but if his lack of interest in human nature led him into this sort of error, he would appear to be unkind and it is doubtful if he would be a very good administrator.

A SENSE OF HUMOR

I would not regard a sense of humor as, in itself, one of the major constituents necessary to the make-up of an administrator, and yet the fact remains that I find it difficult to visualize a really good and effective administrator who is, at the same time, completely lacking in humor. Few people indeed have no sense of humor and some, it must be admitted, have an overdeveloped sense bordering on flippancy and irresponsibility. Short of this extreme, a sense of humor is perhaps most important to an administrator as a corrective of the considerable danger of pomposity, exaggerated idea of personal importance, and indeed, dictatorial tendencies. A person with a true sense of humor can laugh at himself, and such a person can, for example, see the innately ridiculous aspect of running hospital committee meetings as though they were the most important things in the world. It is this sense of balance and proportion which is so important and it is my personal experience that a light touch helps on the most difficult meeting and, if skillfully applied, should not at all be at the expense of the serious business transacted.

These are, then, in my view, the main personal qualities of most importance to an administrator. Quite clearly the list could be added to very considerably as there is no virtue which is not, on the whole, beneficial, nor is there a vice which the administrator would not be better without. I have deliberately not discussed at great length the qualities of efficiency (such as energy, clarity of thought, and so on), but have concentrated upon attributes of basic personality because the efficiency attributes tend to be fairly obvious and also they embrace the entire gamut of possible courses of action. Thus, there is an occasion for speedy decision just as there is an occasion for weighty and careful consideration. There is, however, never an occasion for lack of impartiality or lack of good judgment or lack of courage, and that is why I have concentrated upon attributes of this nature.

THE ADMINISTRATOR IN ACTION

Having built up this paragon of all the administrative virtues, instead of attempting the difficult task of going further and saying what is efficient and what is not efficient, it would perhaps be better if we were to attempt to see this character of ours actually in action and to consider some, at least, of the general principles upon which he relies for doing a really effective and efficient job.

How should he conceive his broad terms of reference? Here we are right up against the factor which is both the challenge and the fascination of the health service, and that is, the purpose for which the hospitals exist (namely, the care and treatment of patients) is something which is entirely outside the direct control of the administrator. The operative word is, of course, "direct."

Indirectly, the influence of the administrator can be powerful and decisive, and it is that which makes the job so infinitely more complicated than that of the average director or controller who is in a position to order and control in detail the operation under his command.

The hospital administrator quite obviously cannot order and control the treatment of patients in the hospital, and it is to be noted that he cannot do this in any significant way even if he happens to be medically qualified. What the hospital administrator can do, and must do, is to ensure that all the activities within the hospital or group operate in such a way that they are directed as closely and efficiently as possible to the care and welfare of the patient. This is absolutely fundamental, and it is surely this which distinguishes a successful from an unsuccessful hospital enterprise.

One of the first things a good administrator has to learn is how and what to delegate. Again without attempting any detailed rules, one may safely say that in almost all circumstances, delegation is a good thing and on the whole, there is not enough of it. I refer, of course, to honest delegation and not mere passing on of unpalatable tasks.

Responsible and proper delegation is almost always successful. One is practically never let down provided one uses average common sense and prudence, and it is much more likely that the subordinate to whom responsibility is delegated will blossom forth in the atmosphere of confidence involved in delegation and will show qualities hitherto unsuspected.

Good doctoring, rightly or wrongly, is more or less taken for granted. It is very much otherwise with administration. A hospital can be very obviously well or badly run and if the organization is bad enough, it can rapidly reflect upon the quality even of the medical service. A doctor cannot do his best for patients if he is constantly frustrated in his efforts to obtain the equipment and supplies which he needs; if everything is muddled or mismanaged and money gets spent on the wrong things, there will be constant ill-feeling, intrigue and lobbying and all those other things which go to make an unhappy group which is, in my view, almost a synonym for an inefficient group. The administrator is accordingly making a tremendous contribution to the direct welfare of the patients when he operates, for example, a sensible, fair and speedy committee structure which, as far as possible, ensures that needs are met in a proper order of priority and without undue delay.

It is, perhaps, more by his indirect influence that the senior administrator can contribute to the general effectiveness of a group. If he makes it his business to see that so far as possible there are no deep rifts between medical staff, nursing staff and administrative staff and committees, he is doing a great deal for the patient. Such a small assignment is not accomplished overnight, nor does it just happen; it requires constant vigilance and constant effort on the part of the administrator. Always he must be prepared not to agree with the indignant criticisms of A regarding B's scandalous behavior, but to find what he can in B's behavior (as reported by A) that might not be so unreasonable and gently to suggest this to A, but not in such a way as to puncture his self-esteem and to make him adopt a defensive attitude if only in order to support his point of view.

Let me say at once that this process is very much duller and less exciting than the more widespread practice of agreeing with one's confidantes what rogues and impossible creatures other people are. I doubt if the person is born who is entirely immune to the subtle flattery of sharing a confidence

which is derogatory to some third party, because the automatic implication is that both the speaker and the listener are above such iniquities as are being ascribed to the third party. Over a coffee break, while out shopping, this sort of thing is pretty harmless, but the fact remains that in administration it just won't do, and every administrator has a positive duty to defend the absent party as best he may, without, of course, being smug about it. His biggest problem arises when the absent party really has sinned and then he must temper his defense with some degree of reality. There do seem to be some hospitals where no two people agree on anything and it is not easy to keep everybody happy most of the time, but there is no doubt that the effort must be made and it will require all the administrator's impartiality, judgment and courage to keep his consultants, matrons, committee members and fellow administrators all seeing things in about the same light, but it can and should be done.

PRIMA DONNAS ABOUND

In a place where there have for many years been deep-rooted suspicions and enmities, it is obviously extremely difficult to eradicate these and yet, at the same time, such conditions provide a wonderful opportunity for an administrator who shows that he can be trusted and is naturally well disposed to all and ill disposed to none. Second, there are undoubtedly some characters of much more than ordinary difficulty, and I sometimes wonder if the hospital service might not have a little more than its fair share! After all, it has the professional trustee, the prima donna specialist whom nobody has ever contradicted, and an undue proportion of unmarried women, many of them in positions of authority. All these characters are potentially difficult, and so it may be that hospitals have rather more than average difficulties in this direction.

The third factor I would mention is one on the credit side, and that is that basically, I believe that there is very little real wickedness and very few wicked characters ordinarily to be encountered in hospital work. Most ill feeling and trouble arises from lack of clarity of thought, misunderstanding, lack of personal confidence, and general suspicion and insecurity. These things are not vices, as such, yet you will find them at the bottom of many serious hospital cleavages. While it is unfortunate that really serious and permanent trouble can be based upon such issues, the other side of the coin is that by practicing and encouraging clear and precise thought and by fostering an atmosphere in which there is no real need for suspicion and insecurity, the administrator can do a tremendous amount toward eliminating trouble based upon clashes of personality and similar matters.

Revised Code of Ethics for Hospital Administrators Released by Joint A.H.A.-A.C.H.A. Committee

THE first revision of the code of ethics for hospital administrators since 1939 has been released by the American Hospital Association and the American College of Hospital Administrators.

Prepared by a joint committee of the two groups, the new code consists of a 10 point statement of principles of conduct. It was derived from a statement of administrative principles for hospitals, hospital administrators, and hospital personnel formulated initially by the joint committee, and included both ethical and operational procedures.

Dr. A. P. Merrill, superintendent of St. Barnabas Hospital for Chronic Diseases, New York City, headed the joint committee which prepared the code of ethics that follows.

PRINCIPLES OF CONDUCT

The hospital administrator's life is dedicated to the highest possible level of performance in the competent and humane hospital care of the sick, in health education in all its many phases, and in research conducted in the interest of hospitals and their patients. In pursuing these objectives the hospital administrator should be guided by the following principles:

1. He will not use his position or influence for selfish personal advantage or gain and will not disparage the work of his colleagues.

2. As the official representative of the hospital's governing body and often the hospital's spokesman in the community, his conduct will at all times be dignified and exemplary. His professional performance will be objective and fair, with the patient's best interest as the ultimate consideration.

3. In his relationships with personnel and staff he will be impartial, tolerant, fair and interested in all reasonable means of promoting personnel morale and welfare, consistent with the hospital's best interests and ability to provide them.

4. The administrator will encourage, assist and teach others the principles and practice of hospital administration to the end that future hospital administrators may be more adequately prepared.

5. The administrator will encourage and participate, to the extent possible, in a broad educational program to assure the health workers necessary to the hospital field.

6. He will contribute his interest, support and leadership toward the general improvement of the community, with especial emphasis on health education and related causes. In so doing he will attempt to avoid involving his hospital in partisan political issues.

7. In his relationships with the medical staff of the hospital he will support that which is constructive, sound and in the interests of good hospital professional practice; he will resist and oppose that which is, in his judgment, harmful, destructive or unwise.

8. The administrator will seek constantly to improve his professional knowledge and skill and will accept counsel and guidance, particularly in fields and subjects with which he is not entirely familiar.

9. Recognizing that his is a position of public trust, he will, within the limitations imposed by good judgment, legal considerations, and his hospital charter respect the rights, privileges and beliefs of others regardless of race, color or creed. He will keep confidential whatever he may learn respecting the private affairs or character of patients and their families, physicians and others with whom he is associated in the hospital. When his administrative duties bring him into conflict with any segment of society or belief, he will deal with the situation with the greatest consideration, courtesy and respect for the individual that is possible, without ridicule or animosity.

10. He will exemplify the Golden Rule in thinking, action and conduct.

Minimum Change Resulted From New Iowa Law on Hospital-Specialist Relations, Survey Reveals

CHICAGO. — For the most part, only nominal changes in the relationship between hospitals and pathologists and radiologists in Iowa have followed settlement early this year of the hospital-specialist dispute there and enactment of a state law defining these services as medical services and requiring them to be identified and charged for as medical services on hospital bills.

This was apparent from a survey of current hospital experience and practice made by The MODERN HOSPITAL.

Some larger hospitals have completed new agreements with specialists, the survey indicated, but the agreements are identical with those that were in effect prior to the dispute, with the exception that terminology now conforms to the terms of H.F. 21, the new law governing hospital-specialist relationships.

SITUATION ESSENTIALLY THE SAME

Smaller hospitals around the state also report the situation essentially unchanged since the new law was passed. In many cases, pathological tissue is still sent to neighboring, larger cities for examination; and doctors in the smaller communities not having resident pathology service have been reluctant to take on responsibility for laboratory and radiology departments, as specified in the law.

By all reports the most complicated aspect of the changed relationship is the necessity, now stipulated in law, for transferring pathology and radiology services from Blue Cross to Blue Shield contracts. According to a recent memorandum to physicians and hospitals from Blue Cross and Blue Shield plans, a year beginning last July 1 was set aside during which, as new members are enrolled and old memberships are renewed, the medical services were to be transferred from Blue Cross to Blue Shield. However, mechanics of the transfer are so complicated that the actual adjustment of benefits had not yet been undertaken late last month, and there was considerable uncertainty as to who would pay the administrative costs of the necessary contract changes, estimated at $33,000 plus additional operating costs of $4500 a month for the Blue Cross plan with headquarters at Des Moines. Transfers from the plan at Sioux City would be an additional expense, it was pointed out. In any event, radiologists and pathologists who promised long ago that the transfer of benefits would be accomplished without any cost or loss of benefits to subscribers are looking the other way, in some embarrassment, as it becomes evident that the transfer will be a costly maneuver.

Following a two-year dispute and a court decision defining pathology and radiology as medical services, H.F. 21 was passed by the Iowa State General Assembly last spring and provided that these departments must be headed by physicians, the names of these doctors must be on hospital bills for such services, and patients must sign admission agreements describing these arrangements. The law also required the transfer of radiology and pathology services from Blue Cross to Blue Shield.

Difficulties in effecting provisions of the new law have centered principally in smaller communities where no resident pathologist is available and other physicians are reluctant to assume responsibility for laboratory services, it is reported.

"Local physicians don't want any one doctor to have the advertising that results from having his name on all hospital bills," one administrator told The MODERN HOSPITAL. At another hospital, the medical staff went on record officially as refusing to name any one doctor or permit any one doctor to assume responsibility for the laboratory.

At still another small hospital, a staff doctor agreed to assume charge of the laboratory, then returned several days later to report that pressure from other members of the medical staff had caused him to change his mind.

In addition to the feeling that doctors having their names on hospital bills would gain a competitive advantage from this "advertising," another reason given for reluctance to assume charge of hospital laboratories is the malpractice hazard. "The doctors have been awakened to the larger legal exposure to which they are subjected when they assume responsibility for the performance of a laboratory," one administrator said. "Most of the general practitioners admit that they know very little about laboratory operation and they are not anxious to take on the increased liability which the law clearly places upon them.

"Two pathologists who have been serving as tissue pathologists for 25 or 30 hospitals in Iowa have refused to assume responsibility for those laboratories scattered throughout the state. Of course, it is impossible to assume that responsibility without giving it some attention, and the time involved in such supervision is not available to these consulting pathologists."

Failure of some hospitals to name physicians in charge of laboratory and radiology departments is one stumbling block to the transfer of these services from Blue Cross to Blue Shield contracts, it was explained. "For proper identification in the handling of Blue Shield claims, it will be necessary to assign special physician code numbers correlated with the hospital so that services rendered can readily be associated with the hospital where [they were] performed," said a Blue Shield memorandum to hospital administrators and medical staff chiefs last month, asking for the names of physicians in charge of these hospital departments.

EXTENDING CREDIT A PROBLEM

Meanwhile, a number of problems remain to be worked out before the transfer of benefits can become effective. Among others, the problem of extending credit to patients entitled to these services is a formidable one. "Hospitals extend credit to Blue Cross patients only because they have contracts with Blue Cross requiring the plan to pay for the services specified," the Iowa Hospital Association pointed out in a bulletin to members. "How Blue Shield will contract with each of the Iowa hospitals so that they will extend credit to patients with Blue Shield x-ray and laboratory service is yet to be determined."

In a memorandum to hospitals dated August 7, F. P. G. Lattner, executive director of Iowa Blue Cross, said hospitals would be advised when details of the transfer and resulting payment methods had been worked out. "Until that notice," he added, "Blue Cross will continue to handle your x-ray and laboratory charges just as we are at present."

Nondenominational Sunday School services are held in the lovely Children's Chapel in the hospital every Sunday morning. The occupational therapy room of Children's Orthopedic Hospital is the subject of this month's cover photo.

Women Run This Hospital for Children

Pictures tell the story of the remarkable activities of women volunteers who have served the patients at Children's Orthopedic Hospital, Seattle, for 50 years

IT TAKES 16,126 women to run the Children's Orthopedic Hospital of Seattle in the style to which its patients have become accustomed. All 16,126 work hard for the institution not only raising funds (they made $403,000 in 1956) but on numerous projects in the hospital itself designed to make life easier for the nurses and pleasanter for the little patients.

The parade of volunteers who serve all areas of the hospital, according to Eva H. Erickson, the administrator, is "a magnificent one." Volunteers bring every child a toy soon after his admission to the hospital, Miss Erickson reports. "A huge play equipment library provides the wherewithal for the play lady volunteers. Birthdays are celebrated once a month. Haircuts are available. Book carts come weekly." All of these are regular services provided to the children and, in addition, there are special events such as a visit from Rin Tin Tin or the Shriners' Circus.

One of the most unusual services performed by the volunteer workers is the production of dresses, blue jeans and shirts for the patients. During the day all children are dressed in "up" clothes, whether they are confined to bed or not. Just being dressed up, especially in the gay attractive garments made for them by the volunteers, does wonders for the children's morale.

For a photographic story of the activities of the volunteer groups, plus some distinctive features of the hospital's regular operation, see pages 64 to 68.

MEMBERS OF THE GUILDS AND AUXILIARIES SERVE THE HOSPITAL IN MANY WAYS

Each afternoon volunteers answer many questions at hospital information desk.

THE volunteer organization that serves Children's Orthopedic Hospital is a remarkable one. The hospital, says the administrator, "is" 16,126 women, organized into 321 guilds and 190 auxiliaries. In 1907, shortly after the first patient was given care, the first guild came into existence. Today, virtually the entire female population of the state of Washington is enrolled in the guilds and engaged in one or more of the countless activities that occupy the volunteers. The board of trustees (all women) has always directed guild and auxiliary activity, and the hospital personnel is in no way involved. The only difference between guilds and auxiliaries, it is explained, is that guild members pay dues individually directly to the hospital, whereas auxiliaries pay dues as a group. In addition, each group has its own fund raising project.

In the record file room, a volunteer is pulling charts for next day's clinics.

Endless hours of service by volunteers are spent in central supply department.

Volunteers run much of the hospital's mail through this addressing machine.

All hospital linens and the children's clothes are made in guild work center.

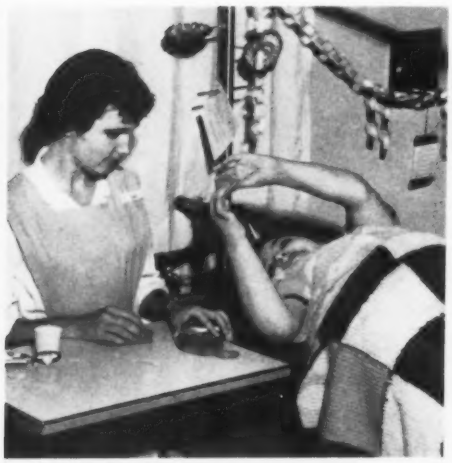
The bright dresses and shirts worn by patients are sewn by volunteers.

Hospitality center not only brings in money but also is corner for relaxation.

VOLUNTEERS SERVE THE CHILDREN: KEEPING THEM HAPPY HELPS THEM GET WELL

IN ADDITION to their work for the hospital, volunteers serve the children directly. They stock a play library with toys and games and bring them to the wards on a play cart. In fact, every child receives a gift from a volunteer soon after he is admitted. Red Cross workers teach children craft skills in the occupational therapy shop. One group of volunteers has become expert at giving haircuts to patients. Another holds a general birthday party each month; all children not on restricted diets share the refreshments. Some 2000 young people are organized into groups called COGS (Children's Orthopedic Guilds) for junior high school pupils and JOGS (Junior Orthopedic Guilds) for senior high school students. They add their interest, volunteer service, and fund raising efforts to those of the senior organizations.

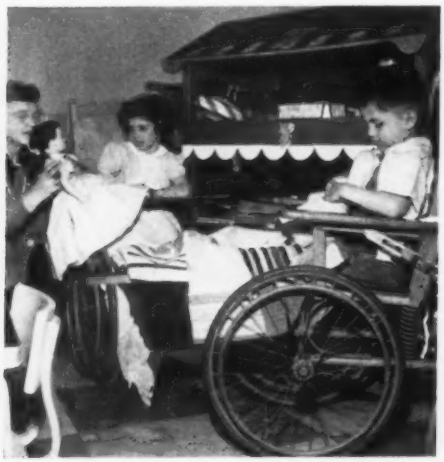
A well stocked play equipment library is available for the play volunteers.



Junior volunteers, over age 16, help while away hours of enforced bed rest.

Each month a general birthday party is held for patients not on restricted diet.

Red Cross arts and skills corps helps children in occupational therapy shop.



The toy cart, with its many playthings, is a welcome sight in ward play rooms.

When each child is admitted he receives a gift, brought by a volunteer.

Haircuts are a necessary part of life in hospital; volunteers act as barbers.

ADMITTING PROCEDURES HAVE CHANGED SINCE THE HOSPITAL STARTED IN 1907

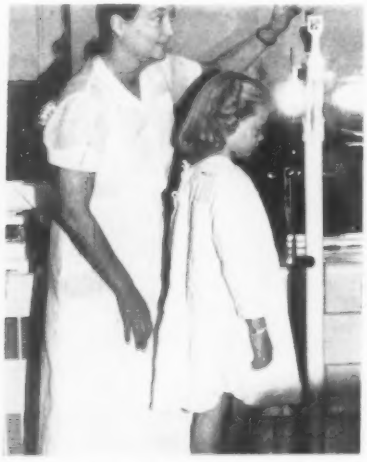
ADMITTING procedures have changed considerably since the first seven-bed ward for crippled children was established in the Seattle General Hospital under the sponsorship of 24 women who comprised the first hospital committee. From that small ward in 1907, Children's Orthopedic Hospital has grown into a 200 bed, six-story institution that cares for 6000 inpatients annually. In 1956, 61 per cent of the hospital care rendered was free and there were 26,000 visits to the outpatient clinics which serve children who are unable to pay for private physicians' services. One-third of the hospital's operating expenses is derived from patients; one-third from bequests, gifts, trust funds and endowment funds, and one-third from the guilds and auxiliaries. A men's advisory board counsels them in finances, but does not enter into hospital operation.

Parent gives child's medical history, "likes and dislikes" to aid in nursing.

During admission, child is given band to help in identification on the wards.

Surgery permits and consents for care are obtained before child goes to ward.

Child is undressed in admitting area; clothing, except shoes, is sent home.

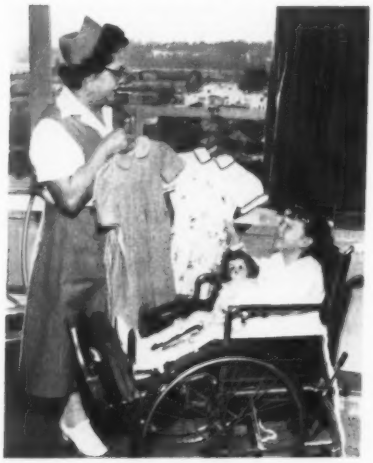


Temperature and weight are charted; bath is given before child goes to ward.

Mother accompanies child and nurse to nursing unit after admitting procedure.

Business officer learns eligibility for free care or arranges the payments.

SPECIAL SERVICES INCLUDE "DRESS-UP" CLOTHING, SCHOOL AND CHILDREN'S CHAPEL



All patients wear "dress-up" clothes; here, girl chooses wardrobe for day.

THE many special services to patients help to while away the long hours and to lessen apprehension about hospital procedures. The preanesthesia Peter Rabbit room is famous. The child goes into the operating room sound asleep, unmindful of bright lights, instruments and masked figures. In post-anesthesia rooms, children returning from surgery are carefully supervised, and other patients do not see the postoperative child until he has recovered from anesthesia. The Seattle public school system provides three teachers who are regularly assigned to the hospital for bedside or classroom instruction. Weekly nondenominational Sunday School services are held in a lovely chapel, lighted by star-shaped fixtures on a blue ceiling. Stained glass windows depict Bible stories, and eight bronze door plaques tell a child's version of the story of creation.

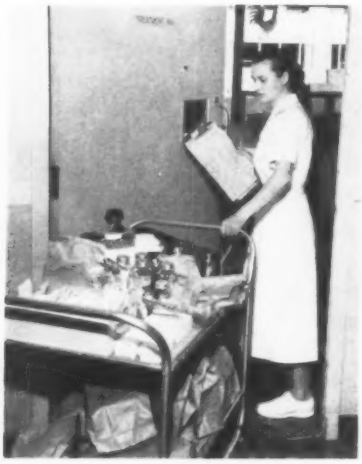
Anesthesia is given in preinduction rooms like the Peter Rabbit room shown here and companion Cowboy room.

Schooling of children is not neglected. Teachers hold classes either at the bedside or in this schoolroom.

The minister greets children at the door after Sunday School which is held in the specially designed chapel.

Brightly patterned shirts and blue jeans are standard costume for boys. Here one makes his choice for the day.

WORK IS ORGANIZED SO THAT THE NURSES ARE FREE TO DO BEDSIDE NURSING



Many times during day central service delivers items to the treatment rooms.

Supplies are kept up to par by central service; a standard check list is used.

Central service picks up items in soiled utility rooms, prepares them for reuse.

Each nursing unit has its own ward clerk (right foreground). Her desk is next to that of the charge nurse.

Linens are supplied for nursing unit use through standard linen carts brought to the floors from the laundry.

Dietary department makes formula for the 50 infants who need it each day.

WHEN more than 16,000 women are interested in what the hospital staff is doing, every wrong move, every delay, every unacceptable act on the part of the employes comes to light. The hospital is promptly made aware of its shortcomings when it fails to give the best care to its patients. Nursing care is vitally important and every effort has been made to relieve nurses of nonnursing duties (some of which are shown on this page) to give them extra hours for bedside care of the children. The director of nursing is concerned only with the nursing division and recovery room, and not central service or surgery. Of her staff, 40 per cent are registered nurses, and 60 per cent are auxiliary personnel. Other services provided for the children's care include diet therapy, audiometry, pharmacy, social service, psychology, physical therapy, occupational therapy, x-ray, EEG, cardiology, photography, surgery and laboratory.

How to Prepare a Nursing Procedure Manual

A nursing manual that contains specific instructions not only for professional nurses but for auxiliary nursing personnel as well is described here. It is intended to do the following:

1. Fix responsibility and accountability for performance.

2. Fix responsibility for direction and supervision.

3. Designate duties according to the skills and knowledge of the various levels of nursing personnel.

4. Eliminate the need for more than one procedure manual.

The manual is especially distinguished by its format which designates the duties of each group in blocks on either side of the page. The duties of the practical nurse, nurse's aide and floor clerk are set in blocks on the left side of the page while those of the professional nurse are on the right side. The net effect is that members of each group can quickly find the section that pertains to their own part in carrying out any given procedure without having to plow through sections that do not immediately concern them. Another advantage of this format is that it makes indexing easier.

ISABELLA TREMOR, R.N.

THE nursing procedures described in this article are intended to fix responsibility and accountability for performance; to fix responsibility for direction and supervision, to designate duties according to the skills and knowledge of the various levels of nursing personnel, and to eliminate the need for more than one procedure manual. It is felt that the outline format used makes it easier to read the contents and also to compile an adequate index, thus making it possible to find desired information immediately.

Miss Tremor is director of nursing service at Cincinnati General Hospital, a unit of the University of Cincinnati Medical and Nursing School. At the time this article was prepared she was director of nursing service, the University of Texas, Medical Branch, Galveston, Tex.

The usual nursing manual does not give much thought to the inclusion of all workers in each procedure. In some quarters, there has been an attempt to set aside certain procedures for nonprofessional workers in manuals with labels such as "Manual for Auxiliary Workers." However, this has not proved too successful. The use of procedures that include the various groups of nursing personnel is not a panacea for all the problems encountered in implementing a procedure program and using nonprofessional workers, but it does help to attain the goal of better nursing care. Everyone becomes more aware of the fact that there are values, limitations and dangers involved in the use of nonprofessional personnel for nursing care, and more cognizant of the need for continuous professional direction and supervision when the practical nurse and nurse's aide are made part of the nursing team.

It is quite difficult to set aside any one group of procedures for any one group of nursing personnel, but it is fairly easy to develop procedures that include the various levels of nursing personnel. In fact the latter becomes essential if one expects to have good, safe and efficient nursing care. There are times when even the simplest nursing procedure should be performed by the professional nurse. On the other hand, there are few, if any, nursing procedures in which all groups of nurses cannot participate.

For example, Mrs. Jones' physical condition may be such today that a

(*Continued on Page* 74)

Examples of Content and Format of Nursing Manual Shown on Pages 70 to 73

Illustration 1—This is a procedure for a sternal puncture. The responsibility for actual performance or assisting the doctor has been assigned to the professional nurse. Here, there is an implied organizational policy that the nonprofessional workers can participate in the procedure to a certain point and that beyond that point the functions do not fall within the limits of their skills and knowledge.

Illustration 2—This is a procedure for the application of a hot water bag. Under the direction and supervision of the professional nurse, the phases of the procedure concerned with performance are allocated to the practical nurse. Here there is an implied organizational policy that these duties are within the limits of the abilities of the practical nurse, but beyond the abilities of the nurse's aide.

Illustration 3—This is a procedure for the application of hot wet packs. Under the direction and supervision of the professional nurse, all of the phases concerned with the assembling of the equipment and performance of the procedure have been allocated to either the practical nurse or the nurse's aide. There is an implied organizational policy that these duties are within the limits and training of both the practical nurse and the nurse's aide. The part of the procedure that deals with giving explanations to the patient and supervising all performances has been assigned to the professional nurse.

Illustration 4—This illustration differs from the others in that it combines the admission procedures of all services into one, instead of writing separate procedures for each service. There are some differences between the admission of general, pediatric, obstetrical and psychiatric patients, but the basic principles are essentially the same. This is true not only of admission procedures, but of most nursing procedures. With the addition of the procedures peculiar to a specific service, the combining of the procedures with accentuation of the differences makes it possible to have one manual for all services. (See pages 72 and 73.)

ILLUSTRATION 1—STERNAL PUNCTURE

I. PURPOSE

A. To obtain bone marrow specimen for a laboratory diagnostic aid.

II. SPECIAL INSTRUCTIONS

A. All of the steps of this procedure may be performed by the professional nurse when necessary. At the direction and discretion of the professional nurse, the practical nurse and/or nurse's aide may perform only those steps indicated as practical nurse and nurse's aide duties.

III. EQUIPMENT AND SOURCE

A. From central supply

1. Sternal puncture tray containing:
   a. Syringes
      1—20 cc.; 1—10 cc.; 1—2 cc.
   b. Hypo needles
      1—#25 x ⅝"; 1—#20 x 1½"
   c. Sternal needles
      1—#19 x ½"; 1—#18 x 1"; 1—#16 x 1⅝"
   d. 6 slides
   e. 2 culture tubes with corks
   f. 1 iodine cup (for cleansing solution)
   g. 1 medicine glass
   h. 1 sponge holder
   i. 1 lap. sheet
   j. 3 surgical towels
   k. 6—4 x 4 sponges
2. Local anesthetic

B. From ward supplies

1. From "Clean Central Supply Area" in the utility room obtain:
   a. Clean-up tray
   b. Sterile gloves

IV. ASSEMBLING OF EQUIPMENT AND PREPARATION OF THE PATIENT

Professional Nurse

1. Explain the treatment to the patient.

Practical Nurse and/or Nurse's Aide

1. Obtain the equipment and place it at the patient's bedside.
2. Screen the patient.
3. Place the patient in dorsal recumbent position with the chest exposed.

V. CARE OF THE PATIENT DURING THE TREATMENT

Professional Nurse

1. Restrain the patient if necessary.
2. Assist the doctor and laboratory technician as necessary.
3. At the end of the treatment, make the patient as comfortable as possible.

VI. CHARTING

Professional Nurse

1. Chart fully and accurately:
   a. Name of the person by whom the procedure was done.
   b. The time the procedure was done.
   c. Unusual signs or symptoms occurring during the treatment.

VII. DISPOSITION OF SPECIMEN

Practical Nurse and/or Nurse's Aide

1. With requisitions which have been prepared by the doctor, deliver the specimen to the pathological laboratory.

VIII. AFTER-CARE OF EQUIPMENT

Practical Nurse and/or Nurse's Aide

1. Rinse all equipment with warm water.
2. Autoclave the equipment before returning to central supply.
3. Place the bedside unit in order.

IX. FINAL CHECKING OF PERFORMANCE

Professional Nurse

1. Check all work of the practical nurse and nurse's aide.

ILLUSTRATION 2—APPLICATION OF HOT WATER BOTTLE

I. PURPOSE

A. To supply heat for comfort.
B. To relieve pain caused by congestion.

II. SPECIAL INSTRUCTIONS

A. All phases of this procedure may be performed by the professional nurse when necessary. At the direction and discretion of the professional nurse, the practical nurse and/or nurse's aide may perform only those phases of the procedure indicated as practical nurse and nurse's aide duties.
B. The temperature of the water must not be more than as follows:
   1. For children over two years of age and adults, 120° F.
   2. For infants under two years of age, 105° F. to 110° F.
   3. Any other temperature must be ordered by the doctor.
C. All hot water bottles must be covered.
D. When applying hot water bottles to unconscious patients, or to those suffering from shock, emaciation, paralysis, and so on, the patient must be covered with a blanket and the covered hot water bottle placed outside the blanket.
E. All hot water bottles must be ordered by a doctor.

III. EQUIPMENT AND SOURCE

A. From the ward:
   1. Hot water bottle
   2. Hot water bottle cover
   3. Pitcher
   4. Bath thermometer
   5. Water

IV. ASSEMBLING OF EQUIPMENT AND PREPARATION OF THE PATIENT

Professional Nurse

1. Explain the procedure to the patient if necessary.

Practical Nurse

1. Assemble the necessary equipment in the utility room.
2. Fill the pitcher with water at the desired temperature.
3. Fill the hot water bottle about ⅓ to ½ full with hot water.
4. Expel the air and fasten the top securely.
5. Dry the bag and apply the cover.

V. PERFORMANCE OF THE PROCEDURE

Practical Nurse

1. Place the hot water bottle on the prescribed area.

VI. CARE OF THE PATIENT DURING THE PROCEDURE

Practical Nurse

1. Make frequent inspection of the area to which the hot water bottle has been applied for signs of leakage and burns, and to be sure that the patient has not removed the cover.
2. Make immediate reports of any adverse symptoms.

VII. CHARTING

Practical Nurse

1. Chart carefully and accurately.
   a. The time the hot water bottle was applied.
   b. The area to which the hot water bottle was applied.

VIII. AFTER-CARE OF EQUIPMENT

Practical Nurse and/or Nurse's Aide

1. Empty the hot water bottle and drain.
2. Inflate with air and close the top.
3. Return to proper storage place.

IX. FINAL CHECKING OF PERFORMANCE

Professional Nurse

1. Check all work performed by the practical nurse and nurse's aide.

ILLUSTRATION 3—HOT WET PACKS

I. PURPOSE

A. To localize infection, reduce pain, and to increase circulation to the affected part.

II. SPECIAL INSTRUCTIONS

A. All steps of this procedure may be performed by the professional nurse if necessary. At the direction and discretion of the professional nurse, the practical nurse and/or nurse's aide may perform only those steps of the procedure indicated as practical nurse or nurse's aide duties.
B. Place the hot plate in a convenient place, but at a distance from the bed and the patient to prevent fire and/or burning of the patient.
C. If the patient exhibits unusual symptoms such as pronounced redness or pain, stop the treatment and immediately report the symptoms to the professional nurse.

III. EQUIPMENT AND SOURCE

A. From central supply
   1. Double boiler with bottom of the upper section perforated.
   2. Hot plate
   3. Wool flannel packs
B. From ward supplies
   1. Waxed paper or thin plastic
   2. Large bath towel
   3. Rubber protector
   4. Bath blanket

IV. ASSEMBLING OF EQUIPMENT AND PREPARATION OF THE PATIENT

Professional Nurse

1. Explain the treatment to the patient if possible

Practical Nurse and/or Nurse's Aide

1. Obtain the equipment and place it at the patient's bedside.
2. Screen the patient and protect from drafts.
3. Place the wool packs in the top of the double boiler and turn on the hot plate.
4. Cut the waxed paper or plastic to a size which will extend beyond the packs.
5. Fan-fold the bedding to the bottom of the bed and replace with a bath blanket.
6. Place the rubber protector covered with a bath towel under the area to be treated.

V. PERFORMANCE OF THE PROCEDURE

Practical Nurse and/or Nurse's Aide

1. Remove a pack from the double boiler, shake out the steam, and gradually apply it to the prescribed area.
2. Cover the pack with waxed paper or plastic, and a dry wool pack.
3. Change the pack every 2 to 4 minutes by slipping out the first pack while the second one is being applied.
4. Continue the treatment for 20 minutes unless otherwise ordered.
5. When the treatment is completed, dry the area treated, replace the bedding, and make the patient as comfortable as possible.
6. Leave the unit in order.

VI. CHARTING

Professional Nurse

1. Record the time of the treatment, reaction and condition of the patient.

Note: If the practical nurse performs the procedure she should be able to do the above charting.

VII. AFTER-CARE OF EQUIPMENT

Practical Nurse and/or Nurse's Aide

1. Place the flannel packs in the laundry.
2. Wash the rubber protector, dry and return to the proper storage area in the utility room.
3. Wash the double boiler and return to central supply.

VIII. FINAL CHECKING OF PERFORMANCE

Professional Nurse

1. Check all work performed by the practical nurse and nurse's aide.

ILLUSTRATION 4—ADMISSION OF THE PATIENT

I. PURPOSE

A. To ensure courteous and efficient admission of the patient to the hospital.

B. To fix responsibility for and to provide a uniform method of handling the patient's personal property on admission. This includes valuables, clothing, and any other personal items that have arrived with the patient on admission.

II. SPECIAL INSTRUCTIONS

A. It is the responsibility of the professional nurse to become acquainted with the new patient as soon as possible.

B. All steps of this procedure may be performed by the professional nurse if necessary. At the direction and discretion of the professional nurse, the licensed practical nurse, the ward clerk, and/or nurse's aide may perform only those steps of the procedure indicated as licensed practical nurse, ward clerk, and nurse's aide duties.

C. The admitting office notifies the ward of the patient's arrival. On the psychiatric service the admitting office notifies the doctor of the patient's arrival and schedules the initial interview with the patient's family if necessary.

D. Emergency patients are sent directly to the ward after the emergency room has notified the admitting office. The admitting office will complete the papers as soon as possible. A member of the family should be sent to the admitting office to give the admission information if possible.

E. Use isolation technic when communicable disease is known or suspected.

F. Even though the admitting office is responsible for retaining the patient's valuables (money, jewelry, etc.) the ward personnel is responsible for determining whether or not the patient has checked his valuables in the admitting office.

III. EQUIPMENT AND SOURCE

A. From admitting office

1. Visiting regulations
   a. "So you are a patient"
   b. "Letters to parents from pediatric department"
2. Admission record
3. Consent form
4. Clothing list

B. From ward supplies

1. Chart supplies
   a. Doctor's order sheet
   b. TPR graphic sheet
   c. Nurses' notes
   d. History sheet
   e. Clinical pathology laboratories sheet
   f. Immunization — Pediatrics
   g. Habit sheet — Pediatrics
   h. Behavior notes — Psychiatry
   i. Insulin sheets — Psychiatry
   j. Labor notes
   k. Delivery room notes — Obstetrics
   l. Nursery notes — Obstetrics
   m. Other special chart sheets and laboratory requisition sheets required by a patient or a department.
   n. Discharge summary
   o. Bedside card indicating service (color)
   p. Name card for chart indicating service (color)
2. Other equipment
   a. Tags for labeling patient's clothing
   b. Scales
   c. Thermometer (oral or rectal as indicated by doctor's standing order or department routine)
   d. Sphygmomanometer
   e. Stethoscope
   f. Card index cards
   g. Wheel chair or stretcher if needed
3. For the patient's unit
   a. Linen supply: bed pan cover, bath towel, face towel, wash cloth, pajamas or gown, bathrobe.
   b. Bedside table equipment: mouth cup, bath basin, curved basin, soap tray with soap, toilet tissue, bed pan, and urinal for male patient

IV. ASSEMBLING THE EQUIPMENT AND PREPARATION OF THE PATIENT

Licensed Practical Nurse and/or Nurse's Aide

1. Check and make sure the patient's unit is equipped with the items listed under "For the Patient's Unit."
2. Go to the admitting office for the patient. Take a wheel chair or stretcher for the patient if necessary.
3. Check the patient's name on the admission record and greet him courteously.
4. Check patient's identification band. Report to admitting office if patient has no band.
5. Take his admission record, consent form, clothing list, visiting regulations, and personal belongings and escort him to the ward.
6. Accompany the patient to his designated unit and offer him a chair or put him to bed immediately.

V. PERFORMANCE OF PROCEDURE

A. Routine General Admission Care of Patient

Licensed Practical Nurse or Ward Clerk

1. Notify the doctor in charge of the patient's arrival.

Licensed Practical Nurse

1. Take the patient's pulse, respiration, and blood pressure.

Licensed Practical Nurse and/or Nurse's Aide

1. Take the patient's temperature, height, and weight as soon as possible.
2. Assist the patient to undress.
3. If the patient needs a cleansing bath, give a tub bath or a bed bath depending upon his condition. If the patient has an apparent skin condition, do not bathe him until the doctor has seen him.

Licensed Practical Nurse and/or Ward Clerk

1. Orient the patient to his unit and the signal system. Give the visiting regulations to the patient. Explain the visiting hours to him and/or his family.
2. Introduce him to the neighboring patients.
3. Orient him to the ward and the hospital routine (time for meals, treatments, doctor's rounds, etc.).
4. Assemble the patient's chart in this order from the top.
   a. Admission record
   b. Consent form
   c. Graphic sheet
   d. Doctor's order sheet
   e. Nurses' notes
   f. History sheet
   g. Clinical pathology laboratories sheet
   h. Clothing list and any other chart sheet required in the service.
5. Print the identification data of the patient on the chart sheets.
6. Place the doctor's order sheet in alphabetical order in the doctor's order book.
7. Print the identification data on medications and treatment and nursing care file cards. Place the cards in the file in the order of bed or room numbers. Print the bed number in lower left hand corner of the medication and treatment file card in pencil.
8. Print on a colored bedside card, which indicates the service, the name of the patient, his age, doctor, and date of admission. Place this card in the card holder on the foot of the bed.
9. Print on a colored card which indicates the service, the name of the patient and the unit history number and place it in the card holder on the chart.
10. Print the patient's name on the TPR sheet and on the diet list.

V. PERFORMANCE OF PROCEDURE—Continued

Licensed Practical Nurse and/or Ward Clerk

11. Print the patient's name, chief complaint, or diagnosis, age, service, date, and time of admission on the Unit Report.
12. Chart the temperature, pulse, respiration, weight, height, and blood pressure on the graphic sheet.

Licensed Practical Nurse

1. Chart on nurses' notes:
   a. Date and time of admission
   b. How admitted
   c. Accompanied by whom
   d. General appearance
   e. Chief complaint
   f. Notification of doctor, the time and by whom
   g. Prosthesis (artificial teeth, eye, limbs, eye glasses, braces, etc.)
   h. Other admission notes as required by a department.

B. Routine General Admission—Care of Personal Property

Licensed Practical Nurse, Ward Clerk and/or Nurse's Aide

1. Take the clothing list to the patient's unit.
2. Send the patient's clothes home if possible.
3. Use the following procedure if clothes are not taken home. Print in ink an itemized list on the clothing list, in the indicated space and describe everything belonging to him which is to remain in the hospital. This includes all personal property that is kept at the bedside, sent to the clothes lockers, and/or to the admitting office.
4. Record on the clothing list "No clothes and valuables," "clothes taken to locker," "clothes and valuables taken home," or "clothes and valuables left at bedside."
5. Explain to the patient and/or his family that he is responsible for any personal property such as jewelry, prosthesis, money, and/or papers, etc., retained at his bedside. Indicate by item on the clothing list if kept at his bedside.
6. Check the clothing list with the patient and/or his family, and have the patient sign it. If the patient is too ill to assume this responsibility, the relative or friend accompanying him will check and sign the patient's clothing list or have the patient sign it as soon as he is able. Have a witness sign if the patient signs with an "X".
7. Place the clothes in his suitcase, or a package.
8. Tag the suitcase, package, shoes, hat, cane, etc., with the patient's name, ward and date of admission. Place the tags so that they are visible. Take the clothes and the patient's clothing list to the clothes locker.
9. Take the valuables and the patient's clothing list to the admitting office.
10. Replace the patient's clothing list in the patient's chart.
11. When any of the patient's clothes or any or all of the patient's other property is obtained for him from the clothes locker or the admitting office during his hospitalization, take the patient's clothing list to the clothes locker or the admitting office where the clerk releasing said property and the person obtaining it sign the clothing list in the indicated space. Have the patient sign the patient's clothing list for said property.

C. Routine General Admission—In Addition the Following Duties Are Performed for:

1. Pediatric Patients

Licensed Practical Nurse and/or Nurse's Aide

1. Use gown and mask technic for all infants from birth to one year of age and on all patients on the pediatric isolation ward.

V. PERFORMANCE OF PROCEDURE—Continued

Licensed Practical Nurse and/or Nurse's Aide

2. Put all clothes except shoes in a paper bag and send home by parents or their representatives.
3. Give each patient a bath. If the patient has an apparent skin condition, do not bathe him until the doctor has seen him.

Professional Nurse

1. Obtain information as to the child's habits from the parents or their representatives and record this information on the habit sheet.
2. Request parents or their representatives to remain until the doctor obtains the history.
3. Explain the instructions for visiting to the parents or their representatives.

2. Psychiatric Patients

a. Closed units

Licensed Practical Nurse and/or Nurse's Aide

1. Collect clothing and all other personal belongings, including any sharp edged or pointed articles, mark with the patient's name, list on the patient's clothing list, and place in the designated area.
2. Give each patient a bath and issue hospital pajamas except on the convalescent (ambulatory) closed units. If the patient has an apparent skin condition, do not bathe him until the doctor has seen him.

Professional Nurse

1. Observe patient's reactions to admission procedure, his illness, and to his hospitalization and record on behavior notes.

b. Open units

Licensed Practical Nurse

1. Do not list clothing and personal belongings which are left in the unit on the patient's clothing list.

Professional Nurse

1. Observe patient's reactions to admission procedure, his illness, and to his hospitalization and record on behavior notes.

3. Obstetric Patients

a. The patient comes directly to the ward

Licensed Practical Nurse

1. Obtain patient's name and name of doctor.
2. Take the patient to the admission room. Assist the patient into a hospital gown.
3. Obtain information about contractions from patient. Time contractions.
4. Obtain required information and record on the first section of the labor notes. Record in remarks space any pertinent information such as edema, known cardiac condition, type of bleeding, etc.
5. Take temperature, pulse, respiration, blood pressure, and fetal heart tone and record on labor notes.

b. Clinic patients

Licensed Practical Nurse

1. Notify obstetrical intern.
2. Obtain patient's clinic record from file.
3. Assist intern in examining patient.
4. Send patient's family to admitting office with admission slip.

c. Private patients

Licensed Practical Nurse

1. Notify obstetrical resident.
2. Assist resident in examining patient.
3. Send patient's family to the admitting office.

Professional Nurse

1. Check all work of the licensed vocational nurse, ward clerk and hospital aide.

(*Continued From Page 69*)

nonprofessional worker might safely give her morning care. But Mrs. Jones may have an emotional problem that requires the help and moral support of the professional nurse; perhaps she is unduly concerned about her current illness, worried about her children, or upset about a multitude of other things that might cause her mental discomfort. The professional nurse can undoubtedly help Mrs. Jones over today's hurdle, and there is no better way or time to give, or at least start to give, this help than while giving bedside care, even though this ordinarily would be within the limits and abilities of the nurse's aide or the practical nurse. By the same token, there might be duties that normally would be assigned to the nurse's aide, but today those duties should be assigned to a practical nurse.

For further example, it might be organizational policy for the professional nurse to assist with all spinal punctures, but there are few instances when a nonprofessional worker could not be assigned to obtain equipment, assist with getting the patient in position, deliver specimens to the laboratory, and take care of used equipment. The assignment of such duties to the nonprofessional worker allows the professional nurse more time for actual patient care and duties that she alone is capable of doing.

However, to prevent confusion and sometimes disagreement, the procedures should be written.

CONSTRUCTION OF FORMAT

Except for the section labeled "Special Instructions" and a few of the construction details, the illustrations on pages 70 to 73 need little or no explanation. The procedures illustrated are not presented for content of sections such as supplies needed and performance of the procedures. It also must be remembered that allocation of duties will vary with each organization. Every organization has its own requirements for selection and training of nonprofessional personnel, and this in turn has a great bearing upon the duties that can be safely and efficiently performed by nonprofessional workers.

The section labeled "Special Instructions" contains instructions that are not involved directly with the actual carrying out of the procedure but that are necessary to assure safe and efficient performance. The first sentence in this section states that the professional nurse may perform the entire procedure if necessary. The second sentence says: "At the direction and discretion of the professional nurse, the practical nurse, nurse's aide, and floor clerk may perform only those phases of the procedure indicated as practical nurse, nurse's aide, and floor clerk duties." This places the responsibility for assignment of duties upon the professional nurse. At the same time it allows her to exercise her own judgment and still be certain that the assignments are in keeping with organizational policies.

This is as it should be because of individual differences in workers. Regardless of the past experience or training of the nonprofessional workers, there are individual differences in abilities which do not allow for safe and expeditious performance of all nonprofessional duties by all workers. These individual differences are factors that make it impracticable to have certain groups of procedures designated as those which *always* will be performed by a specific group of nonprofessional workers.

The last section of each procedure also fixes responsibility for supervision by stating that the professional nurse is responsible for checking all work done by the practical nurse, nurse's aide and floor clerk.

The duties of the professional nurse and the nonprofessional worker are designated in blocks on either side of the page. The duties of the practical nurse, nurse's aide, and floor clerk are in blocks on the left side of the page, while the duties of the professional nurse are in blocks on the right side of the page. One illustration indicates nurse's aide duties on the left side of the page, practical nurse and floor clerk duties in blocks placed in the center of the page, and professional nurse duties in blocks on the right side of the page. Even though this has some merit, it is felt that the placing of all nonprofessional duties on the left side of the page is adequate. To make reading easier and to enhance the appearance of the procedure, these blocks extend only part of the way across the page. Small arrows are used to connect blocks, to indicate flow of work, and to show continuance of the procedure or a section of a procedure on another page.

A margin of 1½ inches has been allowed at the bottom of each page. This sometimes saves the addition of pages to the manual when it becomes necessary to revise a procedure in part or as a whole.

There is a margin of 1½ inches instead of the usual 1 inch margin on the left side of the page. This has been done to allow ample room for housing the procedure in a loose-leaf ring binder, or a similar type of binding.

SUPPLEMENTARY INFORMATION

A written procedure that contains supplementary information in the main part of the procedure becomes cumbersome and difficult to follow. As a rule, when a procedure is used the worker is most interested in knowing such things as what supplies are needed, where supplies are located, who is allowed to perform the procedure, and the mechanics involved in actual performance. However, when procedures are new or performed infrequently it is advantageous to have supplementary information readily available. Therefore, it is suggested that when such information is needed it be attached to the procedure as an appendix, in a manner that will allow it to be removed eventually without disrupting the manual as a whole. This can be accomplished by using the last page number of the procedure concerned and a decimal for each page of the appendix. For example, the last page number of the procedure for doing a sternal puncture is 3. The first page of an appendix for this procedure would be 3.1, the second page 3.2, and so on. This allows the removal of the supplementary information without disrupting the page numbers of the procedure manual.

BETTER INDEXING NEEDED

There has been no illustration or mention of an index in the foregoing, but it might be worth while to mention it at this point. A procedure manual that does not have a good index loses part of its value. Most nursing procedure manuals have been set up with an index that is actually only a table of contents. This can be quite inconvenient to the user because she must go through the greater part of the procedure, at times, when she only wants specific information about obtaining supplies or carrying out a particular part of the performance. The work of making an adequate index should not be overwhelming if the index is compiled at the time each procedure is written or revised.

THE MODERN HOSPITAL OF THE MONTH

Simple lines and lack of "frills," plus economical building materials, kept the construction costs low at Riverside Hospital in Boonton, N.J.

Rock-Bottom Economy Stirs Up a Debate

It is the service a hospital renders, not its looks alone, that counts, say officials and friends of Riverside Hospital at Boonton, N.J. They point with pride to its unusually economical construction even though critics have taken exception to certain aspects of the plan

SIMPLE design, inexpensive materials, and a construction technic that is new for hospitals made it possible for architects and owners to build the 65 bed Riverside Hospital at Boonton, N.J., for substantially less than the average construction cost for several other hospitals of comparable size, according to the project's sponsors.[1]

The total project cost of $13,400 per bed represents a saving of 14 per cent on the average of $15,600 per bed for six comparable hospitals, it was explained. Similarly, the Riverside Hospital cost only $16.92 per square foot, compared to $21.35 for the other hospitals in the group that was studied. (See tables on page 78.)

[1]Architects for the Riverside Hospital were James B. Bell Associates; Slocum & Fuller were the mechanical engineers; Seelye, Stevenson, Value & Knecht, were structural engineers. Otis N. Auer was the hospital consultant.

OUTLINE OF CONSTRUCTION COSTS

Total Project Cost		**$871,000.00**
No. of Beds	**65 (expansible to 100)**	
Cost per bed		**13,400.00**
Total square feet	**40,300**	
Square feet per bed	**620**	
Cost per square foot		**16.92**
Total cubic feet	**533,000**	
Cubic feet per bed	**8,200**	
Cost per cubic foot		**1.52**

These economies were achieved without sacrificing needed space or services, the sponsors insist, and without substituting inferior materials for materials of high quality in any essential parts of the structure.

These claims on behalf of Riverside were questioned by consultants who examined plans and construction details of the Riverside Hospital for The MODERN HOSPITAL. The consultants' comments and replies by the architects and owners will be found on page 76.

The Riverside Hospital is located on an 18 acre tract which is accessible to the population, relatively flat, has frontage on the Rockaway River, and is bisected by the Jersey City trunk sewer. The original concept was of a two-story building with an elevator and heavy construction. More careful estimates of the cost of this building showed it to be beyond the hospital's means, so a reduction in services and beds was considered—to a point where

(*Continued on Page* 78)

CRITICS' COMMENTS AND HOSPITAL'S REPLIES

MAINTENANCE COSTS

We believe that the lack of damage-proof, easy to maintain wainscots in various "hard usage" areas will result in abnormally high maintenance and repair costs. The lack of hard, smooth-surface tile in operating, delivery and utility rooms seems to us to be false economy.

. . . Industrial engineers who investigated this point tell us that the hot sprayed vinyl plastic coatings applied right over colored plastered walls should be extremely durable. Experience to date bears out this view.

CENTRAL SUPPLY

Your central sterile supply room may be too small to service a hospital at its ultimate capacity of 125 beds.

. . . The central sterile supply room contains 678 square feet which compares with the Public Health Service allocation of 520 square feet for a 100 bed hospital. Moreover, the receiving and clean-up area serves both the surgical suite and the rest of the hospital, except for the clean-up in the delivery suite. We do not believe that central sterile supply will have to carry any great volume of raw materials and will draw on the general storeroom several times a week.

MEDICAL RECORDS

The location of the medical records room on the second floor, entirely remote from the centers of doctors' activities, is bad. The problem of dictating records can, of course, be handled by installing any one of the excellent central dictating systems. Such a system would solve the record dictating problem, but would not solve the problem of getting the doctors up to the record room to review and sign records. It looks to us as though the medical record librarian at this hospital would have an unusually tough job.

. . . We suspect your observations and experience lead you to the same conclusion as many administrators': If members of the medical staff do not choose to complete records voluntarily, they are experts at avoiding this job. Stenographic services are centralized and under the general supervision of the medical records department. Remote telephone dictating equipment is provided for surgical and obstetrical procedures only; histories, physicals and progress notes are written by hand by the physicians. A strong policy on this is maintained. Also, we have the medical record librarian use the admissions office, immediately adjoining the doctors' coatroom. She not only sees the doctors when they enter and leave the hospital but has frequent telephone contact with them when they call to make reservations for their patients. A typist-helper will work in the second floor medical records room as required. If a doctor really wants a quiet, pleasant place to complete his records, we have it for him.

AMBULANCE HALL

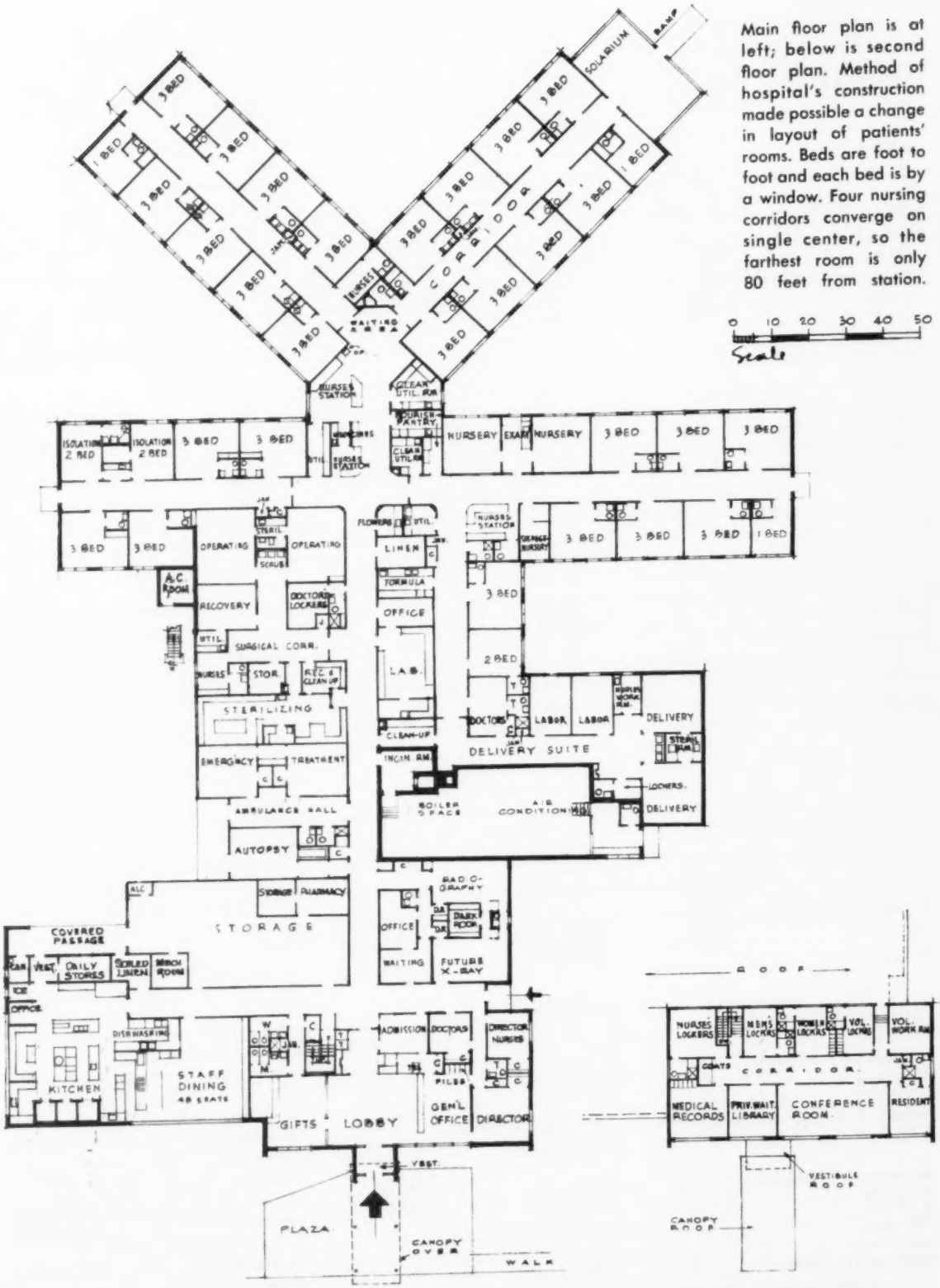
The ambulance hall, adjacent to the emergency rooms, is so small that the area will be badly congested when relatives, friends, police and the inevitable news reporters crowd in with an accident victim.

. . . The ambulance hall is 8 feet wide and 32 feet long. It may be that it does get crowded at times but we find that when there are many visitors some can be persuaded to wait in the main waiting room or the private waiting room, neither being far away. The arrangement of roads, parking and entrances is such that visitors, even in an emergency, would be likely to enter through the main entrance, thus giving the hospital some control.

LOCATION OF KITCHEN

We wonder why the kitchen was located in a place so remote from the patients' area. We believe this creates a difficult transportation and hot food problem. Food carts must go right through the middle of your hospital and we believe that your central corridor is likely to be a congested place during meal serving time. The distance to kitchen from patients' areas would appear to demand some type of special food service.

. . . In the seven or more plans developed, the main kitchen was tried out in many locations. A little thought, and use of a stop-watch, convinced us that the time it would take to push a tray cart, with 20 to 24 trays, from one kitchen to the point of service (less than two minutes) compared favorably with the time it takes to do the same job in a multistory building using elevators. As for congestion in the center corridor, it may be that one tray truck every eight or 10 minutes, at meal time, would cause congestion, but we haven't found it so. Visiting is hardly at a peak during meals.



Main floor plan is at left; below is second floor plan. Method of hospital's construction made possible a change in layout of patients' rooms. Beds are foot to foot and each bed is by a window. Four nursing corridors converge on single center, so the farthest room is only 80 feet from station.

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital and the architects.

(*Continued From Page 75*)
the hospital would have lacked too many really important facilities and would not have had enough beds to provide the necessary operating income to meet operating costs. Some radical change in concept was obviously necessary.

At this point two of the hospital directors who were also contractors[2] suggested concrete slab construction, which they had used in industrial buildings. The figures looked good. But could a hospital bed be put on a concrete slab directly on the ground? Wouldn't it be damp?

USE PLASTIC MEMBRANE

To prevent dampness, an underlying sheet of polyethylene plastic membrane of the kind used for water pipes underground and for insulation in the new trans-Atlantic telephone cable was proposed. In addition, a 2 inch glass fiber insulation strip was inserted under the slab, extending inward 3 feet from the edge on all sides.

One of the reasons for the high cost of hospital buildings, of course, is that they must be fireproof, which generally means concrete, cinder block, brick or tile walls and partitions, with steel and concrete in the roof structure. The weight of such construction necessitates heavy footings and foundation walls and consequent high cost.

[2]Richard Seabury Jr. and Edwin Seabury.

To meet this difficulty a welded steel structure was proposed. Cracks are provided for nailing, and holes for wires and pipes are punched in the material in advance. Insulation of aluminum foil or glass wool is placed between the beams, and steel lath is wired to it and then plastered. Investigation into the use of this type of construction for other purposes was promising, and calculations of strength by structural engineering consultants indicated that this technic would be satisfactory. Certain precautions to avoid damage from moisture and rusting had to be taken, but here again there was an answer in one of the new plastic finishes. Cost studies of this whole approach looked so favorable that it was adopted.

Throughout the building, liberal use was made of insulation. The roof is painted white, and aluminum double-hung windows were provided with an outer pair of sash plus screen so that double glass is provided for all windows and no storage of storm sash is required.

This economical method of construction made possible a departure in the layout of patient rooms. Heavy and expensive walls usually suggest rooms which have their long dimension at right angles to the window, with one bed by the window and the other away from it, in the case of the two-bed room. With the Riverside construction this was not a factor, so the patients' rooms were turned around so that beds are foot to foot and each bed is by a window. This increases the distance from the nurses' station to the end of the corridor, but with the four nursing corridors converging on a single center the farthest room door is only about 80 feet from the nurses' station.

A toilet and a washroom for each bedroom are provided, as are built-in lockers, drawers and table and mirror units.

In patient rooms radiant panels in the ceiling were specified for heat, and each room has individual thermostatic control. Service rooms have hot water baseboard convectors and warm air blown through the ventilators.

The x-ray suite is complete for diagnostic work and a room is provided for future x-ray therapy.

DESIGNED FOR EXPANSION

Two provisions have been made for future expansion. The service facilities are designed to handle up to 100 beds and, with some crowding, 125. Each wing could be extended 36 feet which would add 16 rooms or 32 beds, bringing the normal capacity to 98 and the emergency capacity to 138. Such extensions of the wings would not be costly and would involve a minimum disturbance to the operation of the hospital, the architects say.

Riverside's factory-like appearance and interior innovations haven't pleased some people in the community, it is acknowledged. One citizen remarked that the building just doesn't look the way a hospital should. An out-of-town architect was equally critical, and pointed out that the hospital doesn't have the interior finishes that other hospitals have, and that this, coupled with the use of cheap acoustical materials, cheap walls, and no trimmings, has produced a very plain building.

Replying to these critics, trustees and others who are proud of the hospital deny that it is factory-like in appearance and add that, anyway, it isn't the appearance of a hospital that counts, it's the service the hospital gives.

"Unless we'd used this type of construction, there would be no Riverside Hospital," one trustee observed, ending the argument.

Table 1—Comparison of Costs of Constructing Riverside Hospital With Those of Six Other Hospitals in 34 to 100 Bed Size Range

	Cost Per Bed For Construction Plus Group 1 Equipment	Total Project Cost Per Bed
Average of 6 Hospitals	$12,800.00	$15,600.00
Max.	14,000.00	20,400.00
Min.	10,600.00	13,600.00
Riverside	10,600.00	13,400.00

Table 2—Comparison of Square Foot Costs

	Cost Per Sq. Ft.	Cost Per Cu. Ft.
Average of 6 Hospitals	$21.35	$1.80
Riverside	16.92	1.52

Table 3—Comparison of Number of Square Feet and Cubic Feet per Bed

	Sq. Ft. per Bed	Cu. Ft. per Bed
Average of 6 Hospitals	680	8,100
Riverside	620	8,200
U.S.P.H.S.		
50 Beds	624	—
100 Beds	544	—
Projected for 65 Beds	600	—

Tables above show how construction costs and area of Riverside Hospital compare with similar data from six other hospitals in 34 to 100 bed range.

This Hospital Has Everything Except Money

On a hill overlooking Barstow, Calif., stands a 26 bed hospital, nicely equipped and desperately needed by the community, but it can't open its doors because the city council, which is responsible for the hospital, has no funds to operate it and is forbidden to use tax monies

WILL O'NEIL

A SMALL town with big trouble is Barstow, Calif. The trouble revolves around a small hospital which sits on a hill overlooking the town.

The town needs a hospital, desperately. The one on the hill is a well furnished, well equipped and brand new 26 bed plant, complete with air conditioning and administrator. It has been ready for patients since June of this year, but the town fathers haven't been able to persuade themselves that they can open the doors.

Barstow is in the fearsome Mojave Desert and, like most desert towns, it is bleak, barren and scarcely inviting at all. There are some 10,000 people within the town borders and probably 45,000 in all in its service area, including service by the hospital, if and when.

THERE WAS A HOSPITAL

Until last January Barstow had a hospital, open and serving patients. True, it wasn't very large or very modern or really adequately equipped, but it was a hospital. The osteopathic physicians who owned and operated the little plant closed it up the first of the year in the face of the planned opening of the new Barstow Community Hospital.

In addition to its more or less static population, Barstow and the surrounding highways are subject to a constant ebb and flow of the heavy traffic of California-bound tourists and Las Vegas-bound gamblers. These people, all of whom are in a desperate hurry all the time, all seem to have an unfortunate liking for the center of the highway. This produces considerable medical and hospital business.

The highway cases plus the normal flow of injured and ill patients to be expected in the extensive service area of the Barstow hospital add up to a desperate need for the use of the plant on the hill.

Shortly after the end of World War II a group of Barstow citizens began talking about and agitating for a new hospital for their town. Then, about three years ago, Barstow popped to the head of the list of eligibles for Hill-Burton funds. The town obviously had no time to lose if it wanted those funds.

The group which had done what work was done on the new hospital project had not incorporated or otherwise prepared itself to receive and administer funds. A hasty survey revealed that the only body in town which could accept the funds in the necessary hurry was the city council.

Mayor Leonard Zagortz says that the council believed that it never would be called upon to provide funds for the hospital or its operation, beyond the $511,000 provided from state and federal funds and from funds solicited from local citizens. As citizens contributed to the hospital fund they were assured by the council and other citizens involved that there would be no creation of a tax district to provide funds for operation of the hospital.

So the city council accepted all the monies and assumed legal and moral responsibility for the hospital. Then the blow fell. There wasn't enough money in the hospital fund to complete the construction and equipment of the plant. Because the council had taken responsibility for the hospital without the formal approval of the electorate in a referendum, the city attorney advised the council that it could not, legally, use any tax monies for any purpose in connection with the project, not even as a loan.

But the council found a way. The city had a "civic center improvement fund" which wasn't made up from tax collections. After World War II the military forces donated a group of housing units near the town, and the $60,000 which was transferred from the improvement fund to the hospital fund had been collected as rents on the housing units and not as taxes. The $60,000 was enough to pay off the contractor's last bills and the last invoices for equipment.

HIRED AN ADMINISTRATOR

Last January, as the date for the opening of the new hospital could be seen on the horizon, the city council hired an administrator. The person they chose, Thelma M. Horan, is one of the original group of boosters for the hospital who has, she tells you proudly, worked on the project for eight years.

There were some delays during the spring until the council made the extra money available, but in May, Mrs. Horan hired a superintendent of nurses, a food service manager, and an engineer. Work was stepped up so the hospital could open in late June or early July. But, instead of opening

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ABOUT PEOPLE

Administrators


Wesley D. Sprague

Wesley D. Sprague, administrator of Brockton Hospital, Brockton, Mass., has been appointed associate director of New England Deaconess Hospital, Boston. Mr. Sprague headed the Brockton hospital for five years and previously was assistant director of Newton-Wellesley Hospital, Newton Lower Falls, Mass., for five years. A graduate of Columbia University's school of public health and Hamilton College, he is secretary of the New England Hospital Assembly, trustee of the Massachusetts Hospital Association, and treasurer of the South Shore Regional Hospital Council. He is a member of the American College of Hospital Administrators and the American Hospital Association.


Ward E. Edwards

Ward E. Edwards, assistant administrator of Middlesex Memorial Hospital, Middletown, Conn., has been named assistant administrator of Lutheran Deaconess Hospital, Minneapolis. He is a graduate of the hospital administration program at the State University of Iowa and served his residency at Mary Fletcher Hospital, Burlington, Vt. He is a nominee of the American College of Hospital Administrators.


Dr. George W. Dana

Dr. George W. Dana has been appointed director of North Shore Hospital, Manhasset, N.Y. He succeeds **John M. Danielson,** who recently became administrator of Evanston Hospital, Evanston, Ill. Dr. Dana previously was medical director of the Bingham Associates Fund, Boston, and medical staff director of New England Center Hospital, Boston. Before going to Boston, Dr. Dana was associate dean of the medical faculty at Johns Hopkins University School of Medicine.

Carl I. Flath, hospital consultant of Garden City, N.Y., has been named executive director of Pontiac General Hospital, Pontiac, Mich., succeeding **Lauretta Paul. Warren Simonds** served as acting director in the interim between Miss Paul's resignation and the appointment of Mr. Flath. Mr. Flath served as administrator of Nassau Hospital, Mineola, N.Y., prior to becoming a consultant. He is a fellow of the American College of Hospital Administrators.

John J. Freysinger has been appointed superintendent of Beyer Memorial Hospital, Ypsilanti, Mich., succeeding **Arthur C. Forche,** who has accepted a position as superintendent of the new Annapolis Hospital, Wayne, Mich. Mr. Freysinger is assistant professor of public health statistics at the University of Michigan.

David C. Kreger and **Henry Gotthelf** have been promoted from administrative assistants to assistant directors at Sinai Hospital, Detroit. Both men joined the hospital staff after graduating from Columbia University's school of public health in 1955.


Thomas J. Underriner

Thomas J. Underriner has been appointed administrative assistant at Sacred Heart Hospital, Spokane, Wash. Mr. Underriner is a graduate of St. Louis University's course in hospital administration and served his administrative residency at Providence Hospital, Seattle.

Gordon B. McWilliams has been promoted from administrative assistant to assistant director of Jefferson Medical College Hospital, Philadelphia. Mr. McWilliams, who received his master's degree in hospital administration from Columbia University, joined the administrative staff at Jefferson in October 1956. He served his residency at Hartford Hospital, Hartford, Conn. At the same time it was announced that **John A. Nelson** has been appointed assistant director at Jefferson Medical Hospital. Mr. Nelson formerly was administrative assistant at Methodist Hospital of Brooklyn, N.Y.; he also is a graduate of Columbia University's hospital administration course.

Paul W. Ahlstedt, administrator of Wichita General Hospital, Wichita Falls, Tex., has been appointed administrator of Methodist-Evangelical Hospital, Louisville, Ky., planned as a 400 bed teaching and research unit of the University of Louisville School of Medicine. Construction is tentatively scheduled to start in December.


Eugene E. Tillock

Eugene E. Tillock, former administrative assistant to the psychiatrist-in-chief at Payne Whitney Psychiatric Clinic, New York, has been appointed assistant administrator at Highland View Hospital, Cleveland. He succeeds **John Cartmell,** whose appointment as administrator of the new Suburban Community Hospital, Warrensville, Ohio, was announced in the March issue of The Modern Hospital. Mr. Tillock is a graduate of Columbia University's hospital administration program.

Manfred Flam has been named assistant superintendent of J. J. McCook Memorial Hospital, Hartford, Conn. He formerly was registrar of the Veterans Administration hospitals in Batavia and Buffalo, N.Y., and Newington, Conn., and a medical sales representative for a hospital equipment firm.

Lacy E. Williams has been appointed assistant administrator of St. Luke's Hospital, St. Louis. He is a graduate of the University of Chicago's program in hospital administration and recently completed his administrative residency at North Carolina Baptist Hospital, Winston-Salem.

Elsa C. Lusebrink, R.N., has been appointed assistant administrator of Danbury Hospital, Danbury, Conn. Miss Lusebrink, who has been director of the department of nursing service and education at the hospital, will continue in that capacity and will share additional administrative responsibilities with **Bright M. Dornblaser,** senior assistant administrator.

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How We Put Human Relations to Work

Better communications among personnel in different departments, a self-administered job analysis which brought work disparities to the attention of each employe, and measurable improvement in the results of departmental meetings were three benefits which resulted from a recent two-day institute on human relations conducted for The Doctors Hospital in Seattle. Staged by the University of Washington, the four-session institute was held for department heads, supervising nurses and head nurses

ROBERT F. BROWN, M.D.

A YEAR ago now, this is what happened if a light bulb burned out at The Doctors Hospital, Seattle:

A nurse would call the maintenance department and say:

"This is Wing C. There's a light out up here. Will someone please fix it?"

So an electrician would take his tools and a big, previously stocked service kit containing some 30 types and sizes of light bulbs, go to Wing C, find the nurse and have her point out the unit that needed replacing. He would select the proper bulb from his kit, make the installation and return to his other duties.

But this year, the process runs like this:

The nurse calls the maintenance department and says:

"There is a bulb out in the ceiling fixture in Room 241."

The electrician checks his records for the proper bulb for that fixture, obtains one from the storeroom shelf, takes it to Room 241, and restores illumination.

When the job is done, the nurse hasn't been ruffled by being called from another task to direct the electrician.

The maintenance man hasn't had to carry a bulb kit upstairs, hunt up the right nurse, and wait for her to finish something else to point out the trouble spot.

Neither employe is muttering about the other one's inefficiency.

The elapsed time for the task is reduced.

The hospital's efficiency is greater and patient care has not been interrupted.

The individual patient in Room 241 is served better, giving him less cause for complaint.

In fancier language, more adequate performance and improved human relations have resulted because of improved interdepartmental communications.

IMPROVEMENTS RESULTED

Multiply the light bulb situation manyfold and you have a picture of what has been happening at The Doctors Hospital since last January, when 40 employes attended a two-day institute on human relations on the campus of the University of Washington.

Here are some other results we think are directly attributable to the institute:

Absenteeism among employes is down.

Progress has been made toward elimination of the daily 1 o'clock hassle to prepare vacated rooms for new patients.

Our employes are better identified with the management function of the hospital, and are carrying out the hospital's purposes better than ever before.

Employe merit ratings have taken an upturn.

Overlapping of job assignments is becoming a thing of the past.

Communication between departments is improving and friction is decreasing.

Each employe knows his responsibilities and duties, more exactly than ever before.

Patient criticisms are fewer.

Employe cliques are being broken up.

As hospital director, I conceived the idea for the management workshop as a means of extending the hospital's system of developing administrative responsibility. Frankly, I have been amazed at what we achieved.

The program grew out of discussions of hospital problems at administrative staff meetings. I had suggested four possible topics: interdepartmental understanding, good leadership, efficient dissemination of information to employes, and shortcomings of the administrative staff.

Then I asked for suggestions. Thirteen others were made. I asked for a vote to select topics for study.

"Human Relations" got the largest number of votes, with "Orientation of Personnel" to the hospital's aims and needs a close second. There also was broad agreement that greater interdepartmental understanding was needed, and a high level of approval for the other possibilities I had advanced.

This boiled down to the fact that inadequate human relations were basic to most of our problems.

So we asked the University of Washington to help us put on a two-day institute for our own people. As far as I know, this was the first time the administrative and supervisory staff of one hospital had been brought together for sessions of this kind away from the hospital.

Dr. Delbert C. Miller, associate professor of sociology, was our conference leader. Others on our faculty were

Charles H. Broaded, director of industrial relations for the Fisher Flouring Mills Co. of Seattle, and Dr. Allen Zoll, management education assistant in the office of management development for the Boeing Aircraft Co.

They built the institute program around instruction in four basic skills: group discussion technics, job instruction training, problem solving technics, and methods for reviewing employe performance.

We arranged, by advance planning and careful scheduling of shifts, to have a total of 42 of our 360 employes present for the full two days away from the hospital.

All department heads, all nursing supervisors and head nurses went. Some assistant department heads also attended. Almost all assistant head nurses stayed at the hospital to "mind the store."

Most of the participants reported to the hospital both days; then we utilized definite car pools to take everyone to the campus and back to the hospital at night. Those who lived near the university went directly to the institute from their homes.

As the conference opened on the university campus, I told the group:

"This institute has grown out of your desires. Its purpose is to bring us closer together, outside our everyday surroundings, and to provide us with the leadership we need in this business of human relations.

"The staff of The Doctors Hospital is without peer in its leadership. But there still is room for improvement.

"It is my hope that the institute will enable you who are attending to learn and to grow and to take back to the hospital a practical ability and

THESE GROUP DISCUSSIONS RESULTED IN SPECIFIC SUGGESTIONS

DOES group discussion pay off? Here is what happened at two typical sessions of hospital workers at The Doctors Hospital-University of Washington human relations institute.

One of these groups took up a problem in specific methods of meeting a specific situation. The other group dealt with intangibles in supervisory-subordinate relationships. But both groups came to grips with the problems and arrived at specific suggestions.

Participants, remember, were untrained in this group discussion technic and were at the institute to learn the method, not primarily to solve hospital problems. But their solutions were practical, applicable ones, and many of their "How To Do It" conclusions now are being implemented in hospital practice.

As the groups began, Dr. Miller first gave them these instructions:

"You must learn to think as a group in the way an individual thinks," he said. "The group should mature in the process. All members should think of all the other members of the group, think of helping them participate.

The chairman, he said, needs guides for his action. He must state the problem solving steps that are being used, vocalizing the specific questions to be decided and the important factors in the situation. He must ask what can be done, seeking possible courses of action, noting considerations of reasons for each proposal, recognizing the interpersonal bonds and underlying agreements involved, and exploring differences of fact and opinion.

The chairman must list conclusions from these possible courses. Then he must direct action at ways and means for putting a decision into effect. In all of this, he must hold his own opinions in abeyance, draw out all the members of the group by asking questions, or state examples. He must summarize what has been done as progress is made, preferably using a blackboard to focus attention on what has been done.

The recorder was instructed to prepare a summary of actions as they were taken and decisions as they were made.

The observer, Dr. Miller said, "must be tough minded." He must not participate in the discussion, but must maintain a running check on what the others' participation is like, so that he can report who participates, the quantity and quality of each member's participation, the chairman's behavior, the atmosphere of the group, and so on.

"The observer is useful to you," said Dr. Miller to the group, "only insofar as you use him. This is the way you will grow, by having one person objectively view how you act and feed it back to you.

"Now," said Dr. Miller, "you are on your own. You are practicing a technic as well as engaging in an actual problem solving activity for the hospital."

At Table 5, after chairman, recorder and observer were named, the first order of business was selection of problems for possible consideration.

It didn't take long for problems to be offered. They were:

1. Patients don't like to be taken to the pharmacy to obtain take-home medication, then to the business office to pay for it.
2. When the business office is making out the patient's bill as he checks out, late drug charges at the pharmacy often are forgotten and a supplemental late charge bill must be sent.
3. What can be done to get trays to patients on time?
4. How can we get evening trays out to patients in an emergency?

At this point, a new vote was taken on which subject would be studied in detail.

The question, reworded slightly, was duly noted on the blackboard:

"How can we avoid patient resentment for late charges for take-home medication?"

As discussion went ahead, these points went up on the blackboard:

FACTORS IN THE SITUATION

1. The patient is unhappy with a double bill.
2. His insurance doesn't cover take-home medication.
3. There should be a foolproof way to avoid double charges.
4. Is there a way to educate the doctor, on a staff as large as ours, to give 24 hours' notice of take-home medication?

that your influence should spread to all the employes of the hospital."

Throughout our two days, we learned by actually practicing the subjects we were studying. Conversely, the "instructional material" included actual hospital problems.

We took up Group Discussion Technics the first morning. Dr. Miller assigned each of us to a table and a seat. Each person in Seat No. 1 at each table became the first discussion chairman. Each No. 2 became the first recorder, and each No. 3 became the observer.

Each chairman then called for samples of typical human relations problems as they occurred in our hospital.

"List some typical problems," Dr. Miller said. "Solving some of these will be your goal. Be specific in making this inventory of your difficulties. Get to talking to one another about them."

Then, as we set to work, he told us:

"Group relations, you know, is the most dynamic phenomenon in the world. It never stands still. In your little groups here today you already have started to grow."

He instructed the chairmen:

"Our conferences this morning are like those you will be called upon to conduct in your capacities at the hospital. We will learn how to conduct conferences by conducting them.

"Now we have to remember that naked authority never brings results. Penalties and rewards won't do the whole thing.

"In a society where we all are taught the democratic processes from childhood, democratic relations represent a new kind of authority, based on the self-consent of the group. Self-

WHEN EMPLOYES CAME TO GRIPS WITH THE HOSPITAL'S PROBLEMS

5. There always will be human error and oversight.

6. The credit office doesn't inform the patient when he comes in that there may be take-home medication.

7. Sometimes the patient himself doesn't know he is to have take-home medication.

8. The public doesn't understand how a hospital functions.

WHAT TO DO

1. An intercommunication system could be installed between the pharmacy and the business office.

2. The business office could require a cash payment for all medications as the patient leaves.

3. Since all prescriptions are kept at the pharmacy, the patient could pay at the pharmacy.

4. Pamphlets could be prepared to educate the public.

HOW TO DO IT

1. A pamphlet can be given each patient on admittance inviting him to "Know Your Hospital."

2. Another pamphlet can be placed on the side of the nightstand explaining procedures on "Leaving the Hospital."

3. A definite cash and carry policy can be established for all medications.

Meanwhile, at Table 6, this was going on:

Problems offered for possible consideration as the session got started were:

1. Understanding between shifts.

2. Standardization of supplies through better interdepartmental understanding.

3. Standardizing outpatient procedures and placing responsibility.

4. Interdepartmental understanding in general.

5. Line of demarcation and definition of duties of maids and nurse's aides.

6. Subjugation of emotion to reason in dealing with people.

No. 6 got the vote as being most worthy of detailed study. Up it went on the Table 6 blackboard.

Then the recorder wrote down, under *"Factors in the Situation,"* these points as the discussion started:

1. Self-control under pressure.

2. Lack of control wastes time. Control is time saving in the long run.

3. Organization can prevent pressure.

4. Pride in accomplishment is a factor.

5. The charge person should understand subordinate personnel as individuals.

6. Prejudices are stumbling blocks.

Under *"What To Do,"* here is how thinking was developed in the give-and-take of multiple-brain problem solving.

1. Supervisors should have good health; their physical condition is an influencing factor in avoiding stress.

2. Leaders should develop security and satisfaction. A secure, satisfied person does a better job.

3. Individual conferences with employes can show the supervisor's interest in the individual.

4. Supervisor needs to establish rapport with individuals.

5. Supervisor needs to instill the idea of cooperation between the group and other groups.

6. Subordinates need to be told the importance of their jobs.

7. There should be recognition of good work and constructive criticism of poor work.

8. Constructive criticism must be properly timed to be effective, must be given at the proper place and in the proper emotional setting. The leader must be calm and reasonable himself. The person to be corrected must not be approached while he is agitated.

Then came the *"How To Do It"* listings:

1. Set a good example, be a good leader.

2. Recognize abilities of others.

3. Respect own superiors.

4. Give cooperation in the same degree as it is expected from others.

5. Never take yourself or your situation too seriously.

6. Supervisors must be sincere and congenial.

7. The supervisor must be himself what he expects others to be.

There you have two examples of problem solving.

Whatever else came of the discussion sessions, the participants had tackled some tough problems. In so doing, they had, willy-nilly, become members of the management team.

consent means we commit ourselves to do what is needed for the goal we seek.

"The reason group conferences represent a new kind of tool is that any supervisor knows it is not enough merely to announce an order; he must have the consent of his group. The group must know why the order is necessary, must feel it is a good thing, and be willing to go ahead and do it to achieve the goal as defined.

"Therefore, group conferences have come to be a very important aspect of the administrative process."

By this time, I knew the institute was destined for success. Dr. Miller's words, I am sure, made everyone conscious of his own part in our problem of administering The Doctors Hospital. They turned our thoughts inward on ourselves—to what we were doing and why—as we were doing it.

OUTLINED CHAIRMAN'S DUTIES

Dr. Miller outlined the duties of the chairman, and guides for his operations. He told the recorders to keep notes on what was done, and the observers to "hold aloof" and later tell each table how it had functioned. Then the tables were on their own, until time for reassembling as a general group.

That afternoon Mr. Broaded lectured on job fnstruction training, and demonstrated with an analysis of a typical supervisory training problem in our hospital.

He had us all learn how to make a "sign-painter's cup" from heavy paper, demonstrating, as he taught us this skill, how a supervisor can instruct those under him. Besides the technics, he emphasized the importance of job breakdowns as a valuable tool.

The second morning, Dr. Miller lectured again, this time on problem solving technics in personal relationships. He made his presentation graphic and practical, too, driving his points home by means of tinker-toy structures to represent the intricate complexities of working relations.

And on our final afternoon, Dr. Zoll led us in a study of how to review employe performance. We dispersed into groups of three and used "rôle playing" to practice job review interviews. One person in each group took the part of the supervisor, one took the part of the subordinate, and one was an observer who evaluated the part of each in the coaching procedure and listed ways in which improvement could be attained.

We had a busy, fruitful two days at the institute. This is not just my subjective impression. I know it is true from the changes that have taken place since in our hospital.

I know that I learned a lot; so others must have, too.

We have used administrative staff conferences for department heads for several years. But since the institute, each of our department heads has begun having regular staff conferences with departmental employes.

At our first administrative staff meeting after the conference, there was universal agreement that the hospital needed a job analysis for every employe's position. We now are in the process of preparing these. Each employe is making his own, submitting it to his supervisor, and eventually these will be on file in the personnel office to be used in new employment interviews, and for rating each employe's performances.

Here's how this works.

Frank Fischer, our superintendent of plant operations, says "it's easy to do, because each employe prepares his own." This task of analyzing each job, under supervision, serves to reduce the gap between the employe's actual status and the rôle he has assumed in his job.

Mr. Fischer says it prevents "a plumber from calling himself an engineer."

We found that this project also is preventing the overlap of different jobs in the same department, and eliminating causes of friction between different departments, as well.

For example, we found out that housekeeping employes were cleaning some mechanical equipment, without a knowledge of what was safe or proper, simply because they or their predecessors "always had" done so, or they had assumed this was part of their jobs.

At the same time, skilled labor in the engineering department was being used for chores like putting up venetian blinds, which could be handled by a utility janitor from the housekeeping department.

We think our workers now see their own jobs better and have a better over-all idea of their department's function and its relation to the rest of the hospital. A few workers have suddenly discovered that they really had been underproducing on their jobs; just writing down what their assignment was supposed to be made them conscious of it for the first time.

A good many others are now realizing there are areas of work they did not recognize as their responsibility which actually are part of their jobs.

I think this is especially important in a hospital. In industry, where job assignments are better defined, it may not be. But here, where the interest of the patient is paramount, too often if Joe doesn't get the job done George will, even though it really is Joe's job.

We think now that Joe realizes it is his job, and both he and George feel better about it.

Obviously, this process has greatly increased the flow of information from the administration to subordinates and back again. Besides this vertical movement, there has had to be a greatly expanded horizontal exchange of information.

It is my experience that pressure mounts as communication breaks down. Employes either fight back or run away when the pressure becomes too great.

PRESSURES ARE LESSENED

Now that our communications are better, our pressures are less, and, I am confident, we have fewer workers who feel they have been pushed into a corner from which they must snarl at others, and less need for any to try to escape from us.

Besides this almost "accidental" increase in communications, there have been deliberate efforts to expedite them, also.

We used to have some work order forms for the engineering department's use when repairs or maintenance work or installations were required.

Mr. Fischer has simplified these forms so that the information he needs is readily given. Instead of a blank to be filled in detailing the "Nature of Work," as we had on the old forms, the order form now has only three questions to be answered:

"What needs doing?"

"Where is it?"

"Who wants it?"

(Mr. Fischer, who says he doesn't think a work order can be oversimplified, is the one who solved the light bulb problem, incidentally, by insisting in administrative staff meetings on greater specificity in information. The various department heads have passed the word along in *their* staff meetings. And these monthly

or semimonthly departmental meetings are getting "the word" around the hospital far better than memorandums, directives, bulletin boards, or other methods ever did.)

One thing our department heads are learning, they tell me, is that one of the most important facets of communication is listening—on the supervisor's part.

If the employe gets what is bothering him off his chest, he almost always gets rid of his feeling of frustration whether anything is done about it or not. If the supervisor listens, it shows management's interest.

But as we increase our group conferences—the group choosing its own problem to study, naming a chairman, a recorder, and an observer as we did at the institute—we are finding that fewer and fewer individual complaints are coming up.

Madge Sidney, our executive housekeeper, says in her department these conferences "have solved many a problem."

Our maids and janitors, like our professional workers, now feel freer in offering suggestions or expressing ideas, apparently because they are in a group and need not take a stand strictly as individuals. They like this, and I like it, too.

Mrs. Sidney has instituted an eight-weeks on-the-job training course for each category of employe in her department. New employes take it, and old ones do, too, as new methods are put into use.

She gives examinations at the end of these courses, and merit ratings for her personnel have risen amazingly, with the average grade well above 80.

At one housekeeping department conference, the problem of the daily rush to get beds and rooms made up for incoming patients was analyzed, Mrs. Sidney tells me.

The maids brought the matter up themselves.

The opinion was expressed that our two check-out girls could get the job done most days in two or three hours, figuring 20 minutes for a bed (or 45 minutes if isolation cleaning is required). The problem, of course, was that the peak of demand was a one-hour period from 1 to 2 o'clock.

The discussants, without help from Mrs. Sidney, figured out that if the regular floor maids could help at the busiest hour more beds could be readied and there would be less waiting required of patients. In exchange, the check-out girls could help the floor maids with daily cleaning, at nonpeak periods.

Department heads at The Doctors Hospital, and even the administrator (left center), went back to school to learn the practical application of human relations.

I am happy to say the plan is working fine. But I am even happier to know that Mrs. Sidney's department is solving its own problems in a way that helps the whole hospital provide smoother, better patient care, because this solves my problems, too.

Also in the housekeeping department, the matter of unnecessary absenteeism was brought up—again by the employes themselves.

Some of the discussants put it a bit bluntly when they said they were tired of doing others' work. Others observed that when one worker was absent, the total work done by the housekeeping staff was done less well. "This is bad for the hospital," one of the maids added.

Someway, the recorder noted, the idea seemed to get across that those who were unnecessarily absent might find on-the-job conditions when they returned so tough they would feel impelled to change their ways.

I now can report that some of the worst offenders in this respect voluntarily have found other jobs to be absent from. Some of the others' absences have become less frequent.

I don't think we've solved all our problems, or found a magic wand that will work miracles, of course.

Not everyone felt the institute accomplished as much as it should. One of our department heads, for example, thought the project was largely a waste of time, and that only an elaborate follow-up organization on a continuing basis at the hospital would achieve what we hoped for. (I must agree, in part, with this latter point. But I think the administrative staff is taking care of the follow-up program in its regular meetings.)

Some who attended have had some doubts as to the applicability of the institute proceedings to their own situations. "I can't see how I'll ever use this sort of thing in our department," one head nurse said frankly.

"This is fine theory and I agree with the principles. But in practice in our small, closely-knit department, it's meaningless as far as I can see."

And, of course, we still have problems based on personality differences. No two-day program of any kind could solve these—maybe nothing would.

But these things are minor points, I am sure. In general, the institute surpassed my expectations. Now that we have had several months to give the conference concepts a good trial, I at least have begun to wonder how we ever managed without a conscious, consistent and planned effort to maintain good human relations.

I remember some staff meetings that were brawls. I remember some that were debating sessions. But I don't think we got the job done as well that way, or that our employes felt as good about it then as they now do.

It is my belief that every employe, nowadays, wants more than a paycheck from his job. I think he wants to be a member of a job family, not a cog in a wheel. I think a little prestige goes a long way in giving him a secure feeling. And I hope that we are finding a way to give him that prestige so that both he and the hospital may reap the benefit of his active participation in our program.

Best of all, I think our patients will be the ones who will benefit most in the long run.

Salary Plan Should Include a Rate Spread

Employe friction will be minimized under a salary plan which includes the following features, according to the author.

1. *It should include a minimum and a maximum salary rate for the position, understood at the time of employment, rather than a flat rate salary arrangement which offers no incentives.*
2. *Planned increases should be set up on a percentage basis rather than in equal amounts.*
3. *Rate spread should fit the level of responsibility required of the employe, and the administrator should guard against exceptions to it made as a result of favoritism.*
4. *In administering the plan it is recommended that increases be granted on the basis of merit rather than automatically.*
5. *To monitor the plan a central authority for pay changes must be established and continuous reviews made to keep the rates competitive.*
6. *Department heads must be kept informed and the budgets of the various departments must be kept in line.*

JOHN H. HOLMGREN

IN THIS fourth and final article in the series on developing an equitable salary plan for the hospital, we will discuss the problems involved in establishing salary rates, administering a merit plan, and monitoring the plan.

The objective of the job evaluation program is to price the job. To emphasize a previous statement, if "equal pay for equal work" is to prevail in the hospital, rates for jobs should be fair and equitable. By the time a job analysis of the hospital and a community rate survey have been completed, data have been provided with which to establish salary rates. Step 6 for the coordinator will be to establish salary rates for the hospital pay plan which are fair, based on local conditions, and which recognize the value of each job in relation to the total hospital operation.

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This is the fourth and last of a series of articles by Mr. Holmgren covering methods of determining fair salary rates.

There are several methods of establishing salary rates. Two methods usually considered include: the flat (single) rate and the salary rate. The flat rate carries a single rate for each job regardless of seniority, merit or training on the job. Under this plan all staff nurses earn $240 a month, for example. This is the time method of payment on the basis of a monthly period. Employes may also receive pay on the basis of the hour or week, according to the time worked. The time method of payment is oftenest used as against the piece rate method, based on units produced. It may be that the piece rate system of payment will never be adopted by hospitals to any great extent because of the service nature of patient care and the hospital as an institution concerned with the medical care of patients, rather than a producing company involving machine made products.

Under the rate range plan, a minimum salary is established with several intervening "ladder" steps or increments and a maximum salary which is a "top" salary beyond which administration will not authorize increases. Thus, for a kitchen helper, the job might carry the following rate range:

No.	Increment	Mo. Salary	Period of Eligibility
1	Minimum	$150	
2	1st step	160	3 to 6 months
3	2d step	170	6 to 12 months
4	3d step	180	12 to 18 months
5	Maximum	190	18 to 24 months

The "spread" of a pay scale is the amount of the difference between what is paid as the minimum or entrance salary and the maximum or "top" salary. If it takes six months to be eligible for each step in a rate range, a five-step plan based on six months per step would be a 24 month spread. This spread, as indicated in the preceding example, is known as the "time spread."

Increasingly, the rate range plan is being used in industry and hospital

personnel administration. It has been used in government for many years. It has several advantages over the single rate plan. A discussion of the two methods may indicate this comparison.

The single rate plan of wage and salary administration offers a simple method of payment. This plan simplifies time keeping and payroll accounting. The single rate plan eliminates the problem of granting salary increases to some and not to others, a criticism of the rate range plan. However, the single rate method has certain disadvantages in that it offers little incentive to the employe to do a better job after appointment on the payroll of the hospital. The older employe sees little advantage in maintaining a high work level since his salary is the same as the new employe's. Thus there is no difference in wages based on training, experience or efficiency on the same job.

For these reasons, the rate range plan is recommended in establishing a hospital pay plan. Although it is more difficult to administer, it provides an incentive to employes, helps eliminate turnover, and assists in establishing a criterion for employe recognition and advancement.

In the rate range plan the steps may be spaced in equal amounts, as the $10 steps for kitchen helper shown in the example (called the fixed range), or the steps may be on a constant percentage range. The constant percentage range provides that a given percentage of the base rate (beginning rate) shall be paid for each job as the maximum for that job. This is called the constant percentage limits method. The usual procedure is to apply not less than 20 per cent and not more than 30 per cent of the base rate. Thus, from 20 per cent to 30 per cent would be used and applied against all base rates in establishing all salary ranges in the salary plan. Each range has a per cent limit which keeps each end of the rate scale the same because the difference in per cent between each step is constant.

This method is suggested over the variable percentage range which applies a different percentage to each step in the scale. The upper end of the scale may have a higher value than the lower end as, for example, 10 per cent of the base rate applied in the first step or so and 20 per cent of the base rate applied at the top of the range.

In applying a per cent to the base rate for step increases, the higher the base rate the higher the amount of the salary increase in each step. The following salary schedule is an example of establishing a constant percentage spread of 20 per cent:

FIG. 1—SALARY SCHEDULE FOR A KITCHEN HELPER

Job Title: Kitchen Helper
Salary Rate Range: $150 to $180

No.	% Increase	Amount	Increment
1	——	$150.00	Minimum
2	5%	157.50	1st step
3	5%	165.00	2d step
4	5%	172.50	3d step
5	5%	180.00	Maximum

Spread from minimum to maximum—20%; individual increases per step—5%.

This same percentage plan (20 per cent) may then be used as a control for the other salary ranges in the hospital pay plan. Where a uniform percentage plan is used, it is argued that the dollar spread of each pay scale is "mathematically in proportion to the level of difficulty and responsibility of the class to which it applies."[1] Thus, it indicates to all employes in the hospital that the prospects of salary advancement are in proportion to the importance of the positions they occupy.

A pay plan may also apply a different percentage to the base for each class or group of like positions. Twenty per cent may be applied to the base rate of cooks and assistant cooks to determine the spread between each step, where 25 or even 30 per cent may be applied to the base rate of the registered nurse group, supervisory and nonsupervisory. "In deciding what the spread of a pay scale should be for a given class of positions, the broad guiding principle is that it should fit the class."[2] The spread for any class should be such that it provides an adequate incentive to employes who become highly skilled in the work of the position, where there may be little opportunity for advancement to a higher position.[3]

To set rate spreads effectively, consider the length or breadth of all position rate ranges, the time spread for the class of positions, the degree of promotional opportunity, and the amount of training and experience required as compared to other training and experience requirements found in other classes of position. Certain government pay scales have a wider rate range because a higher per cent is applied to the base rate as a result of the greater degree of responsibility found in the higher type of position.

A job classification and pay plan is shown in Figures 2 to 6, *pp.* 88 and 89.

One industrial company has established pay ranges through the use of the arithmetic mean as a salary control point. After determining what the arithmetic mean rate for the job will be, "the company applies a spread of 10 per cent above and 10 per cent below this mean rate."[4] In general, wide spreads are discouraged because of difficulties in administering or controlling the use of a large spread of pay for the same class of positions.

In considering the maximum of an established rate range, several important principles apply. The maximum rate is the limit of value assigned to a given job or position, taking into account the pay of other classes of positions in the hospital pay plan. It is the rate beyond which an employe will not be paid while performing that job because no matter how well he does the job it was worth so much to begin with, and the limit of its value and the payment for the degree of contribution is reached at the maximum step. The maximum rate is the final control in wage administration which should be conscientiously followed or the pay plan disintegrates, morale suffers, and the administrator is subject to increased individual pressure.

Efforts to circumvent a salary rate range maximum are well known. These include: (1) adding a higher step to the rate range and again calling it a "maximum"; (2) paying favored employes a "bonus" over and above the maximum rate although the employe makes no greater contribution than his fellow workers; (3) promoting an employe (on paper) to a higher rated job even though the work he continues to perform remains unchanged, and (4) permitting excess paid overtime.

An employe has two alternatives once he reaches the maximum rate for a given job. If he has advanced in

[1]Baruch, Ismar: The Structure of a Pay Scale, Public Personnel Rev. 7:141 (July) 1946.

[2]Ibid, p. 142.

[3]Patton, John A., and Smith, Reynolds: Job Evaluation, Homewood, Ill., Richard D. Irwin, Inc., 1952, p. 176.

[4]Hubbell, N. D.: Salary Administration Plan for Factory Supervision and Staff, Office Management Series No. 88, New York, American Management Association, 1939, p. 35.

Fig. 2—JOB CLASSIFICATION AND PAY PLAN (ADMINISTRATIVE—CLERICAL)

Hours per Week	Job Code Number	Job Title	Survey Median Salary (Five Hosp.)	Per Cent Spread	Monthly Pay Steps				
					Min. Step 1	Step 2 3-6 Mo.	Step 3 6-21 Mo.	Step 4 18 Mo.	Max. Step 5 18-24 Mo.
44	101-1	Administrator	$560	30%	$500	$530	$560	$600	$650
44	101-2	Office manager	340	25	300	320	340	360	375
44	101-3	Employment supervisor	335	20	300	315	330	345	360
48	101-4	Senior clerk	260	20	240	252	264	276	288
48	101-5	Bookkeeper	220	20	200	210	220	230	240
48	101-6	Bookkeeping machine operator	190	20	175	184	193	202	210
48	101-7	PBX operator	190	20	175	184	193	202	210
48	101-8	Hospital clerk A	200	20	185	194	203	212	222
48	101-9	Hospital clerk B	150	20	135	142	149	156	162
48	101-10	Receptionist	140	20	125	132	138	144	150
44	201-1	Medical records librarian (MRL)	300	20	280	294	308	322	336
44	201-2	Asst. med. records librarian	250	20	240	252	264	276	288
44	201-3	Medical secretary	220	20	200	210	220	230	240
44	201-4	Medical records clerk	200	20	185	194	203	212	222

Fig. 3—JOB CLASSIFICATION AND PAY PLAN (NURSING SERVICE*)

Hours per Week	Job Code Number	Job Title	Survey Median Salary (Five Hosp.)	Per Cent Spread	Monthly Pay Steps				
					Min. Step 1	Step 2 3-6 Mo.	Step 3 6-21 Mo.	Step 4 18 Mo.	Max. Step 5 18-24 Mo.
40	301-1	Director of nursing service	$400	30%	$365	$393	$420	$447	$474
40	301-2	Supervisor	290	20	270	284	298	312	324
40	301-3	Surgery head nurse	275	20	254	266	278	290	304
40	301-4	Head nurse	262	20	242	254	266	278	290
40	301-5	General staff nurse	250	20	230	242	254	266	278
40	301-6	Undergraduate nurse (More than 2 yrs. training)	220	20	200	210	220	230	240
48	301-7	Ward clerk	220	20	200	210	220	230	240
48	301-8	Orderly	215	20	195	205	215	225	234
48	301-9	Licensed practical nurse	190	20	175	184	193	202	210
48	301-10	Nurse's aide	140	20	125	132	138	144	150

* Shift differentials: Full-time R.N.'s only
3 p.m. to 11:30 p.m.—$20.00 month
11 p.m. to 7:30 a.m.—$15.00 month
Part-time R.N. daily rate—$12.00 to $14.00 day

knowledge and skill, he can attempt promotion to a better job. Or, if he has not advanced himself, he can prepare for eventual promotion to a better job by study and training.

In developing rate ranges for a given series of jobs, as the nursing series, or a given occupational group of comparable positions, rate ranges may be overlapping, as follows:

Staff nurse—$250 to $300
Head nurse—$275 to $350

Another method of establishing rate ranges is to limit the maximum of one job as the minimum of the next higher job, as follows:

Staff nurse—$250 to $300
Head nurse—$300 to $375

The overlapping rate principle is generally recognized as the advantageous method of constructing rate ranges for a pay plan. Overlapping recognizes the principle of promotion to a higher salary rate range in the same occupation without immediate change of pay in order to test the individual on the higher job before advancement in salary is made. The overlapping method also tends to minimize the dollar difference between lower and higher jobs that may contribute to employe friction.

The rate range plan may be administered on an automatic basis of salary increases or on a merit basis. The automatic plan of salary rate increases provides for increases in salary at stated time intervals, as every four months, every six months, every nine months, and so on. Thus, if an employe remains on the payroll, his raises are automatic because of service or seniority. Whether he is unusually efficient or unusually mediocre, he receives an increase following completion of the first time period. At each subsequent period, he receives raises until the maximum of the salary rate range is reached, at which time his rate is "frozen" unless the salary range is changed as a result of cost of living increases or wage adjustments.

The merit plan of salary rate range increases is recommended for hospitals interested in establishing and maintaining a merit program of employe performance. Under the merit plan employes are rated by their immediate supervisors at equal intervals, for example, every six months. A merit rating form is completed and the supervisor rates the employe against other employes on the same job or against a job standard established by supervision. The supervisor rates such factors as the employe's performance, knowledge, interest, ability to get along with others, initiative and degree of responsibility. The final rating of the employe is reviewed by higher supervision and the administrator before a decision is made as to whether merit has been demon-

Fig. 4—JOB CLASSIFICATION AND PAY PLAN (FOOD SERVICE*)

Hours per Week	Job Code Number	Job Title	Survey Median Salary (Five Hosp.)	Per Cent Spread	Monthly Pay Steps				
					Min. Step 1	Step 2 3-6 Mo.	Step 3 6-21 Mo.	Step 4 18 Mo.	Max. Step 5 18-24 Mo.
48	401-1	Dietitian	$340	25%	$300	$320	$340	$360	$375
48	401-2	Assistant dietitian	275	20	254	266	278	290	304
48	401-3	Cook	220	20	200	210	220	230	240
48	401-4	Assistant cook	190	20	175	184	193	202	210
48	401-5	Kitchen helper	130	20	120	126	132	138	144

*Meals included.

Fig. 5—JOB CLASSIFICATION AND PAY PLAN (DIAGNOSTIC-THERAPEUTIC)

Hours per Week	Job Code Number	Job Title	Survey Median Salary (Five Hosp.)	Per Cent Spread	Monthly Pay Steps				
					Min. Step 1	Step 2 3-6 Mo.	Step 3 6-21 Mo.	Step 4 18 Mo.	Max. Step 5 18-24 Mo.
48	501-1	Pharmacist	$335	20%	$300	$315	$330	$345	$360
48	501-2	Pharmacist aide	150	20	135	142	149	156	162
44	601-1	Medical technologist	350	25	300	319	338	357	375
44	601-2	Laboratory aide	150	20	135	142	149	156	162
44	701-1	X-ray technician	350	25	300	319	338	357	375
44	701-2	X-ray aide	150	20	135	142	149	156	162

Fig. 6—JOB CLASSIFICATION AND PAY PLAN (OPERATIONS AND MAINTENANCE)

Hours per Week	Job Code Number	Job Title	Survey Median Salary (Five Hosp.)	Per Cent Spread	Monthly Pay Steps				
					Min. Step 1	Step 2 3-6 Mo.	Step 3 6-21 Mo.	Step 4 18 Mo.	Max. Step 5 18-24 Mo.
48	1000-1	Chief engineer	$515	30%	$450	$484	$518	$552	$585
48	1000-2	Maintenance repairman	260	20	240	252	264	276	288
48	1000-3	Utility man	200	20	185	194	203	212	222
48	1001-1	Housekeeper	200	20	180	189	198	207	216
48	1001-2	Porter	190	20	175	184	193	202	210
48	1001-3	Maid	150	20	135	142	149	156	162
48	1002-1	Laundry manager	250	20	230	242	254	266	276
48	1002-2	Laundry operator	130	20	120	126	132	138	144
48	1002-3	Seamstress	135	20	125	132	138	144	150

strated sufficiently to justify a salary increase within the established salary rate range. Such increases assume that funds for pay advances are budgeted and available in the operating budget of the hospital.

Under the merit plan of employe performance review, the employe is eligible for an increase at predetermined intervals. His increases are not automatic, however, but based on his merit or efficiency and an evaluation of his work. Many hospitals have seen that it is less expensive in the long run to administer a merit review program using rate ranges than to pay single salary rates and experience a higher turnover or the spreading of work over more employes.[5]

[5]Jucius, Michael J.: Personnel Management, Chicago, Richard D. Irwin, Inc., 1951, Chapter 12. Steinberg, M. R.: By Paying Less We Pay More, Mod. Hosp. 72:63 (May) 1949.

Increased payroll costs finally form the basis for increased patient charges. Payroll costs include the greatest percentage of total operating costs, varying from 60 to 70 per cent of total operating costs. A continuous study and review of salaries paid is needed, as well as statistical determination of whether a hospital's payroll costs are going up, down or remaining constant.

MONITORING SALARY PLAN

For these reasons, once the salary program is established, it is advisable to monitor the program to maintain a clear knowledge and understanding, and therefore a control, of payment arrangements. The administrator (or a delegated administrative person) should:

1. Centralize final authority over pay increases, promotions and other actions affecting payroll costs by acting as final reviewer over all such actions.

2. Prepare and distribute a list of employes to each department head, showing employe job title, present salary, and last wage increase for use by the department head in administering the salary plan in his department, including recommendations for salary increases.

3. Discuss the hospital's wage plan with department heads and distribute a concise description of how these policies operate. For example: "All employes are eligible for salary increases every six months, following a favorable merit review, seniority on the job, and the recommendation of the department head. The administrator will approve or disapprove based on. . . ."

4. Establish and maintain a personnel budget for each department.[6]

5. Request work load statistics from

[6]Bailey, Norman D.: Hospital Personnel Administration, Chicago, Physicians' Record Co., 1954, p. 270.

each department head monthly to check on trends in the overage or shortages of personnel based on the work load of each section.

6. Establish a training program for lesser skilled personnel who can develop the skills of the critical and shortage job categories.

7. Distribute job descriptions covering each department to each department head.[6]

As an administrative device, the administrator may suggest to each department head the need for maintaining salary levels near the midpoint of the rate range. The administrator can consider how much over or under salary midpoints various departmental pay practices have developed in the hospital, considering the departments in relation to each other.

SOME ARE MORE LIBERAL

Some department heads are more liberal than others in granting increases. Where a department has a greater percentage of its personnel at the top of individual rate ranges, the administrator can rightfully ask that department head to suspend or delay needed increases until such time as the department having the lowest average salaries has an opportunity to bring some of its personnel up in pay. This concept is not meant to freeze salaries because of greater longevity of service if one department has more personnel of longer service. Rather, it is suggested as one way of looking at the pay problem when funds are limited, requests for salary increases are plentiful, and department heads all maintain the superiority of their staffs.

Another suggestion relates to monitoring pay plans in terms of consolidations and revisions of jobs because of changes in organization. Organization patterns and responsibilities are not static. However, job changes must be determined by methods of organization and assignments of responsibility; personnel should not determine the nature of organization. And the smaller the hospital, the more likely its organization will be influenced by the people who service it.

Periodic reviews of organization and the manner in which jobs are performed and rated will help ensure that the original job classification and pay plan continues to fit the hospital personnel structure. Responsibilities of jobs may be increased or decreased, affecting the established value of the rate ranges. In addition to periodic reviews of departmental operations by the administrator, each department head should request a job review where he believes that a new job is being created or an existing job changed, deleted or consolidated with another.

When jobs are consolidated, the salary assigned the newly developed and combined job should be that paid for the highest of two or more skills. If the duties of a nurse's aide are combined with those of a ward clerk, the salary rate assigned the combined job, (call it nurse's aide-clerk) would be that of the clerk, if it had been established as higher than the aide rate.

In decreasing responsibilities not involving a demotion or in reducing the rate value of a job, the reduced job usually carries a lower beginning rate and maximum rate. In this case, the accepted policy is to continue payment of the higher rate to the employe continuing on the reduced rate job until a new person replaces the original employe on the same job. This policy would also apply after the conclusion of an interhospital salary survey and establishment of a pay plan where selected jobs are reduced in rate value, and employes are earning more in some instances than the established maximum rate. The basis for this is that the job responsibility was decreased and the salary adjusted downward as a result of the employer's reorganization or salary survey and does not reflect discredit on the employe. The employe should not be penalized for changes in hospital job organization or salary rating. However, the employe next hired for the job will negotiate for the job at the reduced salary rate, understanding the requirements and pay before accepting the job.

INCREASE THIS SALARY

For jobs revised upward in responsibility, the employe who remains on the job performing the higher skill and responsibility is entitled to a salary increase following satisfactory demonstration on the job.

Where jobs are deleted, the affected employe should be transferred to a comparable job or, if none exists in the hospital, laid off without prejudice and given an opportunity for the first opening in his skill category.

Following the establishment of a new salary plan and as of the installation date of the plan, all employes receiving less than the minimum rate of pay should be advanced to the minimum salary rate. Those having rates between steps in a rate range may be advanced to the next highest step.

In summary, once the pay plan is completed and rate ranges are established, the present rates of employes on the payroll are slotted into the nearest comparable step of that range. If an employe is below the minimum, his salary is advanced to the beginning rate. If his rate is higher than the maximum established for the job, his rate is "frozen" as long as he remains on that job. Changes in the rate range should not be made as an "accommodation" to employes. Whenever necessary for budget purposes, the administrator can maintain departmental salaries close to the midpoint of rate ranges to balance hospital salary rates. In revising or deleting jobs, adjustments in pay rates should be made if the responsibilities of the job change. All rate changes should be coordinated with department heads and approved by the administrator.

CHECK SALARIES YEARLY

At least once yearly, the administrator or the coordinator should check the salaries paid for key jobs against the salaries paid in the interhospital survey. Cost of living increases, professional shortages, and competition from allied health, industrial and governmental fields are factors that could change the average salary being paid for selected jobs. If the hospitals in the area are members of a formal or informal hospital council or nursing district, such information could be obtained through this organization on a shared basis.

Finally, for additional internal controls, continuous self-analysis of the job evaluation and wage and salary plans will be found through study and the use of such devices as the exit interview and the turnover study. Attention is invited to Dale Yoder's suggestions for this type of personnel research in his book "Industrial Relations and Personnel Management."[7] Objective data, charts, statistics and salary studies can be helpful in pointing up the gaps in a well conceived pay plan, development of "spot favoritism," needed pay adjustments, and other trends which often bring about unnecessary personnel problems in a hospital.

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[7]Yoder, Dale: Industrial Relations and Personnel Management, New York, Prentice-Hall, 1950, p. 89. See also Bailey, Norman D.: op. cit., Chapter 20.

They Talk to Employes From Two Directions

A good employe communications program is the result of several approaches to the problem developed over a period of time, according to Maxine Bishop, director of personnel at Mount Zion Hospital, San Francisco. This hospital holds that employe counseling is the province of the line supervisor. The personnel director, then, undertakes as her particular province to improve communications between administration and the employes. Her first step was the formation of a number of employe councils. Provided they are confined to one topic, general meetings of the employes have been found quite successful.

MAXINE H. BISHOP

HOSPITAL managements tend to be sensitive to the fact that their own employes often have no better understanding of hospital economics and managerial problems than the lay public has—or to the fact that their employes do not demonstrate any particular loyalty to the institution.

Establishing good employe communications in the large hospital is admittedly difficult. The typical hospital lacks the "cohesiveness" that characterizes the average well organized business or industry of comparable size. What, then, are the best means of overcoming some of these obstacles to good communications?

At Mount Zion Hospital in San Francisco we have approached the problem from two directions. We have attempted to increase and improve communications between the line supervisors and their subordinates and we have also attempted to establish direct communications between administration and employe by the use of planned programs inaugurated by the personnel department, acting for the administrator.

This brings up an important question: Is it better for all communications between management and employes to be directed through the line supervisors, making the supervisors entirely responsible for developing and maintaining communications? Or should management's communications with employes be channeled directly from administrator to workers through a staff department, such as personnel?

I believe there is no clear-cut answer to this question. Theoretically, it would be desirable for *all* communications with employes to be directed through the line supervisors. Personal contact between a supervisor and his subordinates gives the supervisor an opportunity to explain and interpret. Because the supervisor has a more personal relationship with the worker than does a staff department, the supervisor might be able to obtain a more nearly accurate impression of the employe's reactions and attitudes.

From a practical standpoint, however, placing full responsibility for employe communications on line supervisors presents a number of problems. It presupposes that each supervisor has a thorough knowledge of the organization's over-all plans, policies and objectives, that each supervisor has completely free communication with *his* own supervisor, and, furthermore, that each supervisor is a skilled communicator, in terms of both informing and interpreting, and of obtaining and assessing employes' reactions. Most supervisors feel pressed for time to accomplish what they consider the production aspects of their jobs and are loath to spend a great deal of time on such intangibles as discussing the organization's policies with their employes.

Many supervisors feel that the over-all interpretation and explanation can be handled most efficiently by a central staff department, or by the administrator himself. Our supervisors have often expressed the view that an explanation of policy and objectives emanating from a central staff department or from the administrator lends weight to information that they have given their employes and thus actually facilitates their communication with subordinates. Furthermore, an adequate and clear explanation of the organization's financial status, policies, the interrelationship of various departmental functions—and particularly the relationship of the individual employe to the over-all structure—requires a great deal of fact gathering, planning and preparation. This is a task that logically can be handled best by a staff department.

For these reasons, at Mount Zion we have felt that communications between management and employes should be developed from *both* directions. Each method is designed to supplement the other. For example, the individual supervisor's explanation of specific personnel policies to his subordinates is augmented by an over-all explanation from the personnel department of *all* personnel policies. Or the individual supervisor's explanation of new programs or activities of the hospital is supplemented by information furnished to employes directly by the administrator.

Employes' reactions or attitudes toward the over-all policies or programs as expressed to their supervisors are relayed to the personnel department or to the administrator. Conversely, general programs of communication presented by the personnel department or

"In the conduct of day-to-day personnel relations, the personnel department chiefly acts as adviser or expediter to line supervisors"

by the administrator are usually followed up by supervisors through individual discussions with their employes. Any employe attitudes or reactions as expressed to the personnel department are discussed with department heads and supervisors with a view toward correcting any adverse situations that may exist, or modifying existing programs or policies.

SEVERAL METHODS USED

We have used several methods to increase communication between supervisors and their subordinates. The administrator, through periodic meetings of department heads, attempts to keep them informed about the hospital's financial situation, occupancy rate, budgetary matters, union negotiations in progress, expansion or building improvement plans, or new programs. Department heads use their own judgment as to how much of this information to pass on to their employes. Every department head is encouraged to hold regularly scheduled meetings with employes, both for the purpose of informing employes and of giving them the opportunity to ask questions, make suggestions, and discuss problems. The departmental staff meeting is growing in frequency and popularity at the hospital. Sometimes members of the administration or representatives from other departments are invited to the meetings to discuss specific matters of interest to the group.

Nursing service employes are organized into various "councils," with each council representing a different level of position, such as supervisory staff, general duty nurses, vocational nurses, and so forth, with a coordinating committee responsible for maintaining liaison among the different councils. These councils have formal constitutions and by-laws, and are conducted according to parliamentary law. Their purpose is to provide a means for the staff members to present for discussion problems that have arisen in the course of their work, to make recommendations for improvement of methods, patient care or personnel practices, and to provide a means of communication between the staff and the director of nursing service.

One of the councils—that composed of the supervisory staff—has been fairly effective in initiating and carrying out several projects such as an inservice education program consisting of periodic lectures and films on medical or nursing topics, and revision of the nursing procedure manual. The councils composed of other levels of nursing personnel have for the most part been ineffectual. Employes have not shown an interest in participating in the councils, they have undertaken no projects, and they are reluctant to discuss job problems in council meetings.

For the most part, interpretation of personnel policies to employes and employe counseling on job problems is handled by line supervisors. The personnel department, through frequent personal contact, attempts to keep department heads informed of all personnel policies and their interpretation. In turn, department heads often consult the personnel department about specific personnel matters and they discuss jointly various ways of handling the situations.

The actual working out of a problem *with the employe*, however, is handled by the supervisor unless he specifically requests that a member of the personnel department talk to the employe. Employes, of course, are free to come to the personnel department at any time to discuss problems, and they frequently do; but in the conduct of day-to-day personnel relations, the personnel department primarily acts as an adviser or facilitator to the line supervisors. Biweekly meetings are held between the personnel director and department heads to discuss personnel subjects. Meetings are devoted to predetermined subjects agreed upon by the group. For example, a series of meetings was devoted to the development of an employe performance rating plan. When agreement on a program is reached by the group of department heads, discussions are extended to first-line supervisors and to employe groups in order to involve them in final development of the program.

In addition to employe communications directed through the line supervisors, we have made a number of attempts to promote general communications through central programs.

The objectives of these programs have been the education of employes regarding the hospital, stimulation of pride in the hospital's contribution to the community, and establishment of channels through which employes might make suggestions or voice opinions and attitudes regarding the hospital.

FORMED EMPLOYES' COUNCIL

The first attempt at over-all employe communications was the formation of an employes' council, the organization of which was planned by a joint committee of department heads and employes. The council's objectives were (1) to promote communications between employes and management; (2) to increase opportunities for employes to participate in hospital affairs, and (3) to encourage employes to submit suggestions and ideas regarding the hospital's operations. An election procedure was established whereby a minimum of one nonsupervisory employe would be elected by each department, and, in the large departments, one person was elected to represent every 25 employes.

The elected representatives appointed a committee to draft a constitution and by-laws, following which they elected their own officers. Their constitution provided for regular monthly meetings. In addition to the offices of chairman, vice chairman, secretary and treasurer, it provided for three standing committees: (1) an employe management advisory committee to promote communication between employes and management, to consider and recommend to management ways of improving hospital procedures and operations, and to assist in the interpretation of hospital policies to employes; (2) an information committee, to plan ways of keeping employes informed of the

"The greatest weakness in the council is lack of communication between its representatives and the employes they represent"

activities of the council and to participate in the publication of an employes' newspaper, and (3) an activities committee, to plan and organize employes' recreational and social programs.

The employes' council was in existence nearly three years and its accomplishments were disappointing. In retrospect, we believe that at the time it was established it improved employe morale to some extent, mainly because of the close contact it necessarily established between the council representatives and some representatives of management (primarily the personnel director). This was important at the time the council was formed. Morale was very low among certain groups of employes, and fortunately for us, employes who had considerable influence with these groups turned up as active members of the council. By increasing these employes' understanding of management's objectives and attitudes, we were able to allay many fears and suspicions that had previously prevailed among the groups.

The council served another purpose. It helped the employe representatives become acquainted with representatives from other departments and thus fostered a greater spirit of unity, at least among those employes who were serving on the council.

NOT A VITAL FORCE

On the debit side, the council did not become a vital force in the hospital, in relation either to management or to employes. Management had expected it to be much more dynamic and creative than it actually was. Management more or less assumed that the council would develop a program centered on improvement of patient care or employe morale, and the council did not do so. The employe-management advisory committee made a number of suggestions to management. Management did not take them too seriously because many were impractical and also because management knew that most of the recommendations emanated from only one or two members of the council and were not representative of employe thinking.

The greatest weakness in the council was lack of communication between its representatives and the employes they represented. The council simply was not a voice of employes, and this fact detracted immensely from its standing with both management and employes. It also was difficult to maintain active interest on the part of all the representatives. Most of the council's work was carried on by very few representatives. Because of the way the council was organized it was difficult for management to give it any leadership or clear direction. The council was independent of management. It planned and ran its own affairs, and management representatives did not attend any of its meetings unless they were invited to do so. Any guidance, therefore, was necessarily given obliquely through the chairman, a method that did not prove highly successful.

Written communications with employes have consisted primarily of an employes' bulletin, the *Stetho-Scoop*, published monthly by the personnel department, and an employes' manual entitled "You and Mount Zion Hospital."

The *Stetho-Scoop*, which was named as a result of a contest among employes, has steadily increased in popularity. Most of its content is contributed by employes. An employe editorial board and employe reporters representing all departments plan the issues with the help of the personnel department. The employe editors have done an excellent job of maintaining interest among the reporters. Each month they submit a large quantity of employe and departmental news that has been of high quality in both informational and interest value.

The employes' manual, which was distributed to all employes, and is routinely given to every new permanent employe as he is hired, has sections devoted to: (1) history of the hospital, how it is financed, its organization, and the functions of each department; (2) a description of all employe benefits, such as health insurance coverage, hospital discounts, the personnel health program, dining and parking facilities, and so forth; (3) a description of all employe activities; (4) an explanation of all personnel policies, and (5) a map of the hospital.

We have made limited use of employe bulletin boards, restricting them largely to safety posters and also to newspaper clippings of all articles appearing in the local newspapers about the hospital.

STICK TO ONE SUBJECT

The general employe meeting has proved an effective communications device when it has been devoted to a specific subject of concern to employes, when it has been thoroughly planned well in advance of the meeting, and when it has not been held too often. The first general employe meeting devoted to a specific subject was held when the hospital administrator conceived the idea of giving all employes an annual report of the hospital. The meeting was sponsored by the employes' council, whose chairman presided and introduced the administrator. The meeting was combined with the annual service pin awards to employes celebrating their fifth, tenth, fifteenth, and twentieth anniversaries with the hospital. The presentation of awards immediately followed the administrator's report. The program was followed by a buffet supper which was planned, prepared and served by employe volunteers with guidance from the dietary department.

In his report to employes, the administrator included a detailed but highly understandable presentation of the hospital's finances, its occupancy rate, its functions, its teaching and research programs, and plans for improvement of physical facilities and expansion of patient care programs. This was the first thorough introduction employes had had to the over-all

operation of the hospital, and the program met with enthusiastic response from employes.

In 1955, the personnel department inaugurated an employes' orientation program, consisting of a total of 5½ hours. The orientation sessions are mandatory for all present employes and for new employes as they are hired. The sessions were held every week until a majority of the present employes had attended. They are now scheduled on a regular basis twice a month.

Part of the program is devoted to a general orientation to the hospital. A one-hour presentation, using slides taken of employes at work in all departments of the hospital, and accompanied by a narration, describes in detail the hospital's over-all operation, and the part each department and each employe plays in the hospital's work. The slide presentation is followed by a tour of all departments.

DISCUSS PERSONNEL POLICIES

The remainder of the orientation is devoted to a discussion of all personnel policies, benefits and activities. This session is conducted along conference lines as far as possible with the group participating by identifying those personnel policies, benefits, or activities that the members want discussed and by asking questions as the session progresses. Even though *all* personnel policies, benefits and activities are covered before the session is over, having the employes identify the subjects they want discussed has been quite revealing of their attitudes toward particular policies. Problems of particular concern to the group have frequently been disclosed through these orientation meetings.

We are constantly attempting to evaluate the program content in terms of employes' reactions. Before the orientation program was established, the employes' council was asked for, and gave, suggestions about its subject matter. The slide presentation was previewed by department heads and supervisors before it was shown to employes and changes were made, based on recommendations from the group. After the first few sessions were held with employes, the personnel director met with department heads and asked for their evaluation of the program in relation to reactions received from their employes. The employes' council was asked to help evaluate the orientation program by having a representative interview each employe who attended the sessions and send the interview results to the personnel department on an interview form, without showing the name of the employe interviewed. A number of changes have been made in the content of the program as a result of reactions from employes.

It is extremely important that information given to employes be valid and honest and that employes accept it as such. Information should be factual, with such explanation and interpretation as will help employes understand it, but without any attempt to slant the data in any way. Employes should not be propagandized. They detect readily efforts at propaganda and react unfavorably to them. Even if the information furnished to employes is entirely factual and unbiased, they may be distrustful of the material and *think* it is distorted in favor of management. This situation, when it occurs, goes to the roots of the hospital's personnel relations. If employes are suspicious of the hospital's handling of personnel matters, they can hardly be expected to trust information given them by management. On the other hand, the firm, consistent and fair administration of personnel relations, based on principle rather than expediency, goes a long way indeed toward gaining employes' acceptance of information passed down from the administration.

UNION MEETING HELPFUL

What we believe will prove to be our most successful means of direct personal communication with all employes was stumbled upon accidentally. About two years ago, we began working with one of the unions representing our employes regarding the establishment of a classification and pay plan. The contract covered approximately 100 heterogeneous jobs spread among a number of departments and representing a number of occupations. After the hospital submitted a tentative classification and pay plan to the union, the union membership elected an employe committee to meet with the hospital's personnel director and the union business representatives. Membership on the employe committee was rotated among the departments or particular job classes that were under discussion, so that altogether about 15 employes served on the committee.

The results of the study were extremely gratifying. Not only did it end in complete agreement between the hospital and the union, but it also significantly increased mutual understanding between the hospital management and the individual employes concerned. We plan to use the same method, *i.e.* meetings between management and committees of each of our union groups and our nonunion employes, in obtaining employe participation in the development of a performance rating plan that is now under study.

NO ONE MEDIUM ENOUGH

Our experiences to date have led us to believe that employe communications must be developed through a number of different directions. No one medium is sufficient. As a result of our experience with the employe council method, we believe it is ineffectual to establish an elaborate mechanism of communication and then expect communications to begin flowing. We believe all communication has to be based on concrete problems, proposed programs, or actual happenings that are of direct concern to employes. It is unrealistic, we now realize, to give employes an abstract objective and expect them to create a program around it. We have also had better results in direct employe communications when we have worked with fairly homogeneous groups, *i.e.* employe groups that have common problems. We believe one of the inherent weaknesses in the employes' council was the fact that the employe representatives did not have enough in common with each other.

We believe that the most effective program of employe communications at our hospital is one that is built on the following foundation:

1. Give employes as much information as possible about all phases of the hospital's operation, and about all policies and activities that affect them, and make certain that the information is honest and unbiased.

2. Work with small employe groups, stratified according to our contractual agreements, in the development of any important personnel program that affects them.

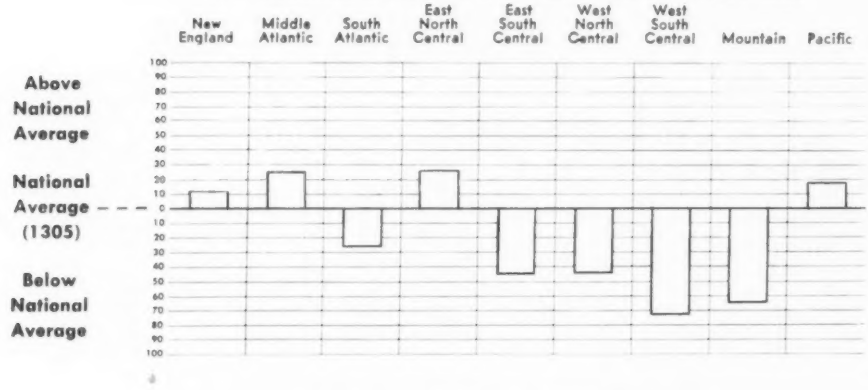
3. Rely on effective supervision, accessibility of personnel department staff to both department heads and employes, and close liaison with union representatives to keep us alert to employe attitudes and to help us detect without delay any areas of employe dissatisfaction or specific job problems.

Regional Variations in Hospital Statistics

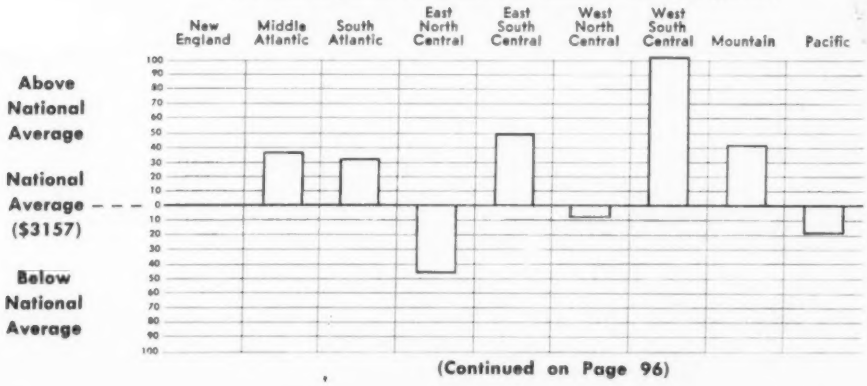
This study shows regional variations among psychiatric hospitals as to size of hospital, total assets per bed, plant assets per bed, expenses per patient day, payroll per patient day and number of full-time personnel per 100 patients

LOUIS BLOCK, Dr. P.H.
Chief, Research Grants Branch
Division of Hospital and Medical Facilities
Public Health Service, Washington, D.C.

SIZE OF HOSPITAL (Psychiatric Hospitals)
Per Cent Regional Variation From National Average (1305 Beds)

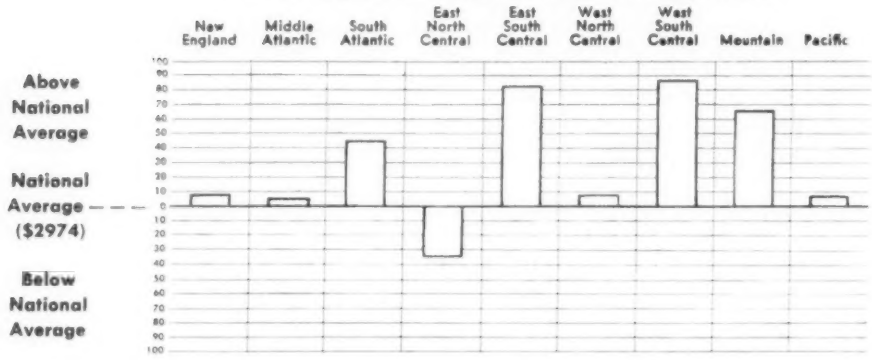


TOTAL ASSETS PER BED (Psychiatric Hospitals)
Per Cent Regional Variation From National Average ($3157)

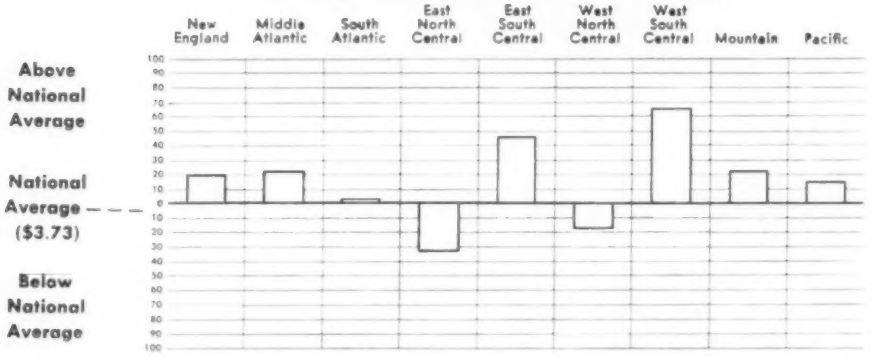


(Continued on Page 96)

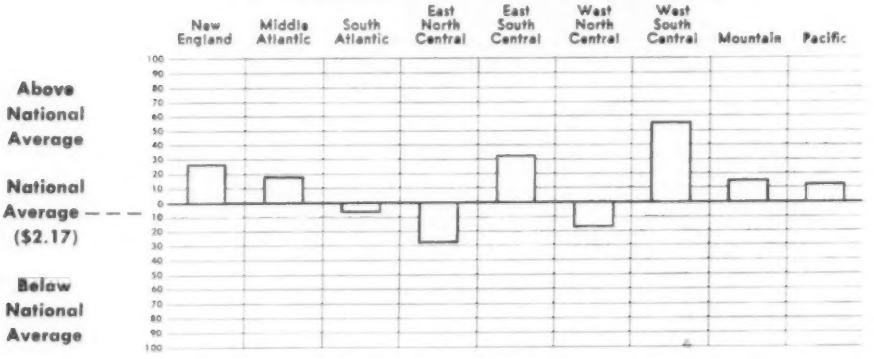
PLANT ASSETS PER BED (Psychiatric Hospitals)
Per Cent Regional Variation From National Average ($2974)



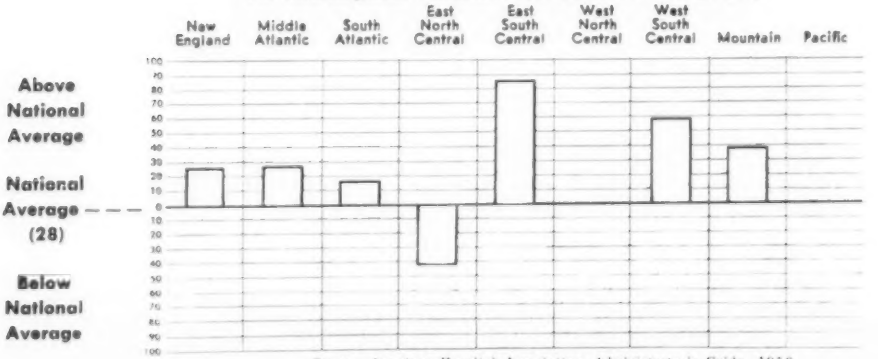
EXPENSES PER PATIENT DAY (Psychiatric Hospitals)
Per Cent Regional Variation From National Average ($3.73)



PAYROLL PER PATIENT DAY (Psychiatric Hospitals)
Per Cent Regional Variation From National Average ($2.17)



FULL-TIME PERSONNEL PER 100 PATIENTS (Psychiatric Hospitals)
Per Cent Regional Variation From National Average (28)



Source: American Hospital Association, Administrator's Guide, 1956.

B.F.Goodrich develops new surgical glove that reduces hand fatigue, fits comfortably without binding

"Surgiderm" is first glove to have ideal combination of comfort, sensitivity, strength

A new rubber glove, just developed by B.F.Goodrich, is so much more comfortable than other surgical gloves that it has to be tried to be believed. It's softer, more pliable. It fits easily, snugly; doesn't bind the hand or restrict the freedom of the fingers. The difference is so obvious you can feel it just by putting this new B.F.Goodrich "Surgiderm" glove on one hand and comparing it with any other glove on your other hand.

It's the use of a newly-developed rubber compound that makes possible —for the first time—this ideal combination of comfort, sensitivity, and strength in one glove.

Less tiring to the hands

Comparison tests prove that the B.F. Goodrich "Surgiderm" glove is 30 to 50 per cent softer than any regular rubber surgeons' glove, including the brown cement type. Because it's softer and more flexible, it takes 25 to 30% less force to flex the fingers and hand, a tremendous factor in reducing fatigue.

More sensitive touch

The new glove is extremely sensitive to the touch, responsive to even the slightest movement of the fingers. It is tissue thin, and uniformly thin—no heavy ends at the fingertips.

Stronger, longer lasting

Despite its softness and thinness, this B.F.Goodrich glove is strong to start with and stays strong even after many sterilizations. It is 36% stronger than a brown cement type glove *before* use, 67% stronger *after* ten sterilizations. What's more, it keeps its elasticity, can be stored for months with no danger of deterioration.

Ask for test pair at A.H.A.

This new glove will be shown at the American Hospital Association Show, in Atlantic City, starting September 30. We invite you to stop by our exhibit and obtain a free pair of "Surgiderm" gloves for comparison testing by one of the surgeons on your staff.

Where to buy

The new B.F.Goodrich gloves are made in sizes from 6 to 10, have rolled wrists which fit snugly over the gown, are brown in color. They're sold by hospital supply houses and surgical dealers everywhere. *Hospital and Surgical Supplies Dept., B.F.Goodrich Industrial Products Co., Akron 18, Ohio.*

B.F.Goodrich

SURGEONS' GLOVES

How to Measure Laboratory Productivity

A method for determining relative productivity in sections of the laboratory where the processes require widely varying times is the subject of this phase of a continuing study by the authors

EDMUND P. FINCH and SEWARD E. OWEN

THE application of performance and productivity study methods to the management of hospital laboratories involves many new concepts. The procedures and methods presented here have been developed over a period of seven years and are currently in use at the Veterans Administration Hospital, Hines, Ill.

METHODS

For a long time we have felt that something useful should be done with the increasing volume of statistics accumulating in our files month by month. As was pointed out in a recent article by D. H. Starkey,[1] "records kept in the form of numbers of specimens examined are valueless except for making comparisons of activity of the same laboratory from month to month or year to year."

Our interest has been focused on the departmental echelon rather than the laboratory level. It is well known that there are similarities in the patterns of activity of the various sections.[2] We have tried to link these apparent regularities with other knowledge so that some basic general information might be developed. It was felt that in spite of the many diverse situations covered by the word "performance," various factors could be developed which would enable one to compare the work performed in apparently dissimilar sections of the laboratory such as bacteriology and hematology, histology and biochemistry.

It is important to maintain a complete record of work done in each section. The tests need not be counted the same way by everyone unless interlaboratory comparisons are to be made. However, it is essential that the method used in tabulating tests be consistent; one must also know how many tests were done and how long it took to do them.

TESTS PER MAN-HOUR

In our laboratory, printed daily work sheets list the tests for each specialty. Space is provided to tabulate the number of each type of test done. There are five different sheets for the various sections and they are maintained in the work areas for daily posting. At the end of the month the figures on the work sheets are totaled and transferred to a single page recapitulation form, from which data may be obtained to calculate average daily and monthly imposed work loads and test distribution.

One of the easiest of several productivity factors to determine is that of tests per man-hour (TMH). To obtain this figure, one divides the total number of tests done in a department by the number of man-hours required to complete them (eight hours a day times the number of working days times the number of persons in the section). Under certain conditions, tests per man-hour is a reliable factor and can be used where one wishes to follow work load distribution and trends. It must be remembered, however, that the results may be altered by one of several situations.

One of these may be described as a "light work load." It does not cause a large error; in fact we ignore it in our calculations because there is little that one can do about it. For example, in biochemistry a person working a eight-hour day performs chemical tests for approximately seven hours and prepares solutions and reagents for one hour.

Thus, in calculating the tests per man-hour a seven-hour test load is divided by an eight-hour day. This situation may be experienced in nearly every department where the daily test load is completed in less than eight hours of working time. This cannot be corrected because the daily test load (unless prescheduled) is dependent upon what the physician orders for his patients. In large laboratories that provide service 24 hours each day, it is best to be slightly overstaffed to compensate for Saturday and Sunday duty.

(*Continued on Page* 100)

The authors are, respectively, supervisor, Unit 1 laboratory, and chief of the laboratory section, Clinical Laboratory Service, Veterans Administration Hospital, Hines, Ill.

Published with the approval of the chief medical director. The statements and conclusions published by the authors are the result of their own study and do not necessarily reflect the opinion or policy of the Veterans Administration.

[1] Starkey, D. H.: How Much Work Is Done in Your Laboratory, Hosp. Management **82**:74 (July) 1956.

[2] Owen, S. E. and Finch, E. P.: How to Calculate the Laboratory Work Load, Mod. Hosp. **88**:102 (June) 1957.

Table 1—Clinical Laboratory No. 1
Work Load and Staff Factors

Specialty or Department	Tests per Year	Tests per Man-Hour	% Total Load	% Total Time	Optimum Balance Factor (O.B.F.)	O.B.F. Times TMH (C.P.I.)
Bacteriology	60,340	3.1	11	21	1.91	5.9
Biochemistry	150,566	6.5	29	25	0.86	5.59
Hematology	258,890	7.4	49	38	0.77	5.69
Histology	9,687	1.6	2	7	3.50	5.6
Parasitology	21,437	5.2	4	4.5	1.12	5.8
Serology	24,566	5.9	5	4.5	0.90	5.3*
Total	522,486	5.7	(weighted average)			

*This figure cited as an apparently low C.P.I.

Table 2—Clinical Laboratory No. 2
Work Load and Staff Factors

Specialty or Department	Tests per Year	Tests per Man-Hour	% Total Load	% Total Time	Optimum Balance Factor	O.B.F. Times TMH C.P.I.
Bacteriology	60,970	4.8	29	34	1.17	5.62
Biochemistry	68,065	6.5	32	28	0.87	5.66
Hematology	62,562	7.5	30	23	0.77	5.78
Histology	3,343	1.6	2	6	3.0	4.8*
Parasitology	3,937	3.8	2	3	1.5	5.7
Serology	9,936	4.8	5	6	1.2	5.76
Total	208,783	5.7†	(weighted average)			

*An example of a one-man department where apparent load is not up to departmental capacity.

†Weighted average—Total load for laboratory divided by total time of persons performing tests on the bench. Time of pathologists, secretaries, morgue attendants, and animal caretakers not included.

Persons working these day and night shifts ordinarily take their compensatory time during the regular Monday through Friday work week, leaving the section relatively understaffed for that day's work load.

Another influencing factor is that of lost time. This is the result of annual leave, compensatory time off, and sick leave. This does not have a significant influence when a large department is involved, or where the time measurement is made over a relatively long period. We do not subtract leave of this type from the departmental total in calculating the various factors.

A third variation is caused by the manner in which the tests are counted. It was this apparent discrepancy which led us to undertake this investigation. Under our system of counting tests, we encountered the following situation: In hematology, each task done is usually counted as a test; for example, a red cell count, differential, sedimentation rate, hematocrit and hemoglobin are each counted as a single test. A similar situation exists in the biochemistry section where sugar, urea and chloride determinations each count as a single examination.

However, in histology one might work all day cutting and staining sections from one or two necropsies and receive little credit for tests performed per day because of the manner in which these are counted. Similarly, in bacteriology, a culture is one test regardless of whether one or many organisms are isolated and whether one or several days are needed for isolation and identification of the organisms encountered. Thus, the question propounded was this: Is the person who works in histology or bacteriology doing only 1.6 or 3.1 tests per man-hour respectively as busy as, or busier than, the individual in the hematology section turning out 7.4 tests per man hour?

TWO NEW FACTORS

The answer to this question seemed to lie in the development of two new factors. One we have called the "Optimum Balance Factor" and the other "Productivity Index." For the former, two basic figures must be known for a department. One of these is the percentage of total laboratory time used in the specialty. The other is the percentage of the total laboratory test load that is done by the section. Dividing the percentage time by the percentage work load results in the optimum balance factor. For example, using the figures listed in Table 1 for hematology, this section did 49 per cent of the laboratory load in 38 per cent of the time. Dividing 38 by 49, one obtains 0.77 as the balance factor.

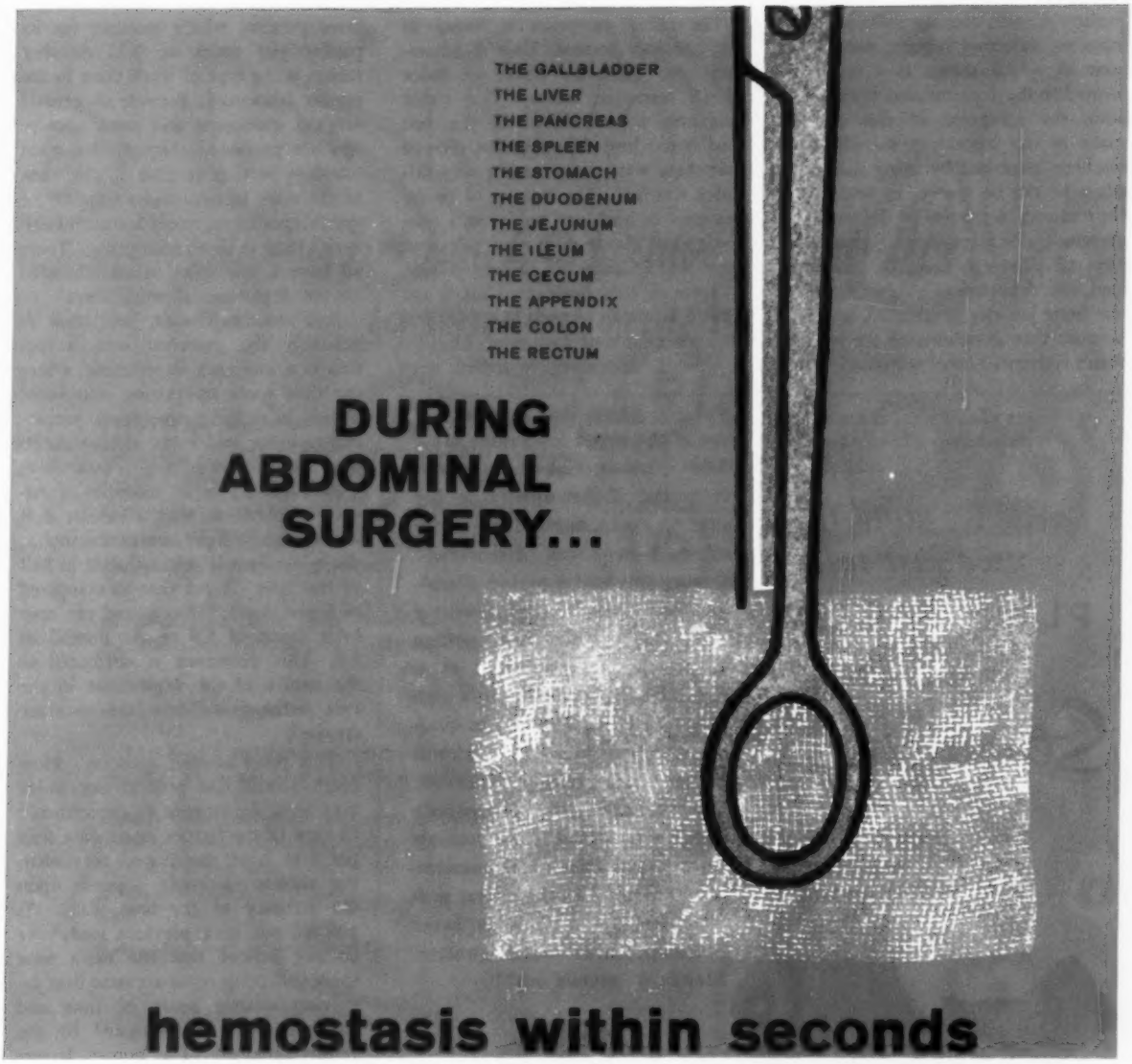
The productivity index is just as simple to obtain. This results from multiplying tests per man-hour for a section by the optimum balance factor. In our laboratory (see Tables 1 and 2) this index seems to range from 5.6 to 5.9, with two exceptions. One, as seen in Table 1, occurs in the serology section, which is a two-man department where the daily test load is apparently not quite up to their capacity.

This situation illustrates one of the variations mentioned previously, namely, a light initial work load (that ordered by the physician). There is more than enough work in the section to keep one man busy but not enough "countable" work for two. The word "countable" is used to indicate that the No. 2 man is quite busy with tasks such as injecting mice for the

Table 3—Comparison of Tests per Man-Hour, Balance Factors, and C.P. Index for Labs 1 and 2

Specialty or Department	Tests/Man-Hour		Optimum Balance Factor		Comparative Productivity Index	
	LAB. 1	LAB. 2	LAB. 1	LAB. 2	LAB. 1	LAB. 2
Bacteriology	3.1	4.8	1.91	1.17	5.9	5.6
Biochemistry	6.5	6.5	0.86	0.87	5.6	5.7
Hematology	7.4	7.5	0.77	0.77	5.7	5.8
Histology	1.6	1.6	3.50	3.0	5.6	4.8
Parasitology	5.2	3.8	1.12	1.5	5.8	5.7
Serology	5.9	4.8	0.90	1.2	5.3	5.8

Note that the departments which have almost identical factors are those in which the daily tasks are very similar to countable "tests." They are hematology and biochemistry.



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Prolan "A" test, making colloidal gold solutions, injecting rabbits, and so on, none of which shows as a test performed on the departmental work sheet. Since the inception of this control study in our laboratory the situation has been remedied by using this man, when he can be spared, to help other departments temporarily depleted by vacations, sick leave, and compensatory time off. On the basis of countable load, this department is approximately one hour per day overstaffed, and this is more than compensated for by this man's activity in other sections.

The other exception is found in the histology section, Unit 2 laboratory (see Table 2) where an index of 4.8 seems to indicate that either this unit is overstaffed or the test load is too low. Investigation showed that there were three reasons why this index was low. The manner of counting tests in histology results in a relatively low figure for tests per man hour when compared to hematology; in spite of this, however, Unit 1 and Unit 2 histology sections have identical test per man-hour factors of 1.6.

Unit 1 laboratory is staffed with three persons, which accounts for its productivity index of 5.7. Another reason is the type of work done in the smaller laboratory. Because all general surgical specimens and most necropsies are processed through the main histology section at Unit 1, the work of the other section consists mainly of special specimens, research tissues (animals) and a few necropsies. These all have a low value when tabulated on the departmental work sheet.

Still another factor, and this is probably the principal one, is that this is a one-man department where the time spent sharpening microtome knives, in staining procedures, preparing reagents, and other similar duties does not count as a "test." Parasitology (see Table 2) is an example of another department with a similar staff and test load (2 per cent of the total); the work there is accomplished in half of the time (3 per cent as compared to 6 per cent). Thus a test per man hour figure of 3.8 results instead of 1.6. This difference is attributed to the nature of the work done in the two sections, and how the tests are counted.

This poses another question: How much should the productivity index vary from department to department? In view of the factors influencing tests per man hour, mentioned previously, the answer obviously depends upon the accuracy of the basic data. As pointed out in a previous study[3] we do not believe that the extra time spent collecting super-accurate data involving quarter hours of time and fractional tests is warranted by the results obtained. The human factors involving the technologists cannot be equated as closely as a statistic can. Consequently, from Table 3, one would say that a plus or minus deviation of 0.2 (3.5 per cent) in the index from 5.7 is normal. In our laboratory, the figure 5.7 was obtained by dividing the total number of examinations by the total man hours worked. Using 100 per cent of the work load and 100 per cent of the time, one obtains unity for the optimum balance factor. This, when multiplied by the tests per man hour, 5.7, results in the over-all figure of 5.7 for the productivity index. This figure is relatively low because our laboratory is open 24 hours every day and persons covering the 4 p.m. to

[3]Finch, E. P.; Owen, S. E., and Byers, W. E.: Clinical Chemistry Work-Load Factors, Clinical Chemistry 2:427 (December) 1956.

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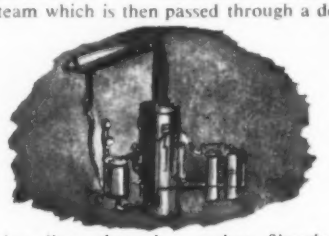

mineralizer, through a carbon filtration unit and then is introduced into the evaporator of the still. Final distillation removes traces of bacteria, organic matter, etc. Write for Bulletin #145 to: Barnstead Still & Sterilizer Co., 31 Lanesville Terrace, Boston 31, Mass.

midnight and the midnight to 8 a.m. shifts at night are on duty for emergencies only; their work load does not match that of the day shift personnel.

Also, under our system of tabulating work done in the various specialties, tests from the transfusion section are combined with those from hematology. The transfusion section, in the main laboratory, is a two-man department. Our regulations state, and sound practice dictates, that duplicate and separate crossmatchings be set up for every unit of whole blood leaving the transfusion section for patient care. Thus we have a dually staffed department, but no test credit is received for the duplicate tests since work of a checking nature should certainly not be counted twice.

However, some compensation is achieved because the transfusion section performs approximately 950 to 1000 prothrombin time determinations per month. If these tests were transferred to serology section (Unit 1) the tests per man hour there would rise to 8.8; the optimum balance factor would become 0.64, since the percentage of work load would increase from 5 per cent to 7 per cent. The new balance factor, multiplied by 8.8, would result in a productivity index of 5.6 for serology. This illustrates the value of placing work where time for performance is available, rather than in a technically logical section.

DISCUSSION

The material used in this study, tabulated in Tables 1, 2 and 3, was taken from laboratory records covering the fiscal year 1956 (July 1, 1955, through June 30, 1956). It has been our experience that several consecutive years should be studied before any definite conclusions may be drawn. Graph A shows how the work load varies from month to month. A future study will investigate the possible reasons for this. From information presently on hand, we believe that there are many factors influencing this monthly test load line.

Table 1 shows the tests per man hour by specialties in a large general medical and surgical hospital. In addition, this table shows each department's percentage of total work load and percentage time spent in its accomplishment. Table 2 gives similar data for a clinical laboratory serving a large hospital whose patients are those with a chronic type of illness involving hospitalization over a long period of time

New Hill-Rom All-Electric ("Push-Button") Hilow Bed

• This modern, safe and efficient hilow hospital bed saves much time for the nurse by eliminating unnecessary trips to the patient room or unit. The patient has access to the head and knee rests and does not need the nurse for routine adjustment of the spring. If the patient's position is not to be changed, the nurse can flip the cutout switch for the head rest or knee rest—or both—making the push-button controls inoperative. Only one motor unit does the entire work of operating this all-electric bed. Fully approved by the Underwriters' Laboratories as safe for use with oxygen.

Head and footboard panels, designed by Raymond Loewy, are covered with Teakwood grain Farlite, a pressure laminated plastic which is impervious to alcohol, iodine and other ordinary chemicals used at the bedside, and is also heat resistant. Also available in other woods and finishes. A satin-finish stainless steel band protects the top sides and bottom of the panels. Cut outs in center of headboard for cervical traction, and on the sides and head of the footboard for lateral frames.

Procedure Manual No. 3, by Alice L. Price, R.N., M.A., explaining the correct usage of Hilow beds, is available for student and graduate nurses.

(For further information on this new push-button Hilow bed, see other side of this page.)

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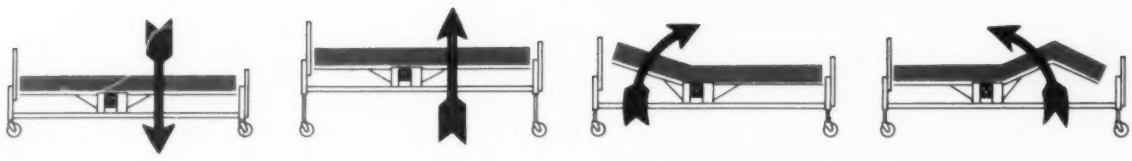

low position *high position* *head rest* *knee rest*

Safety sides do not interfere with use of the patient control panel.

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● This all-new, all-electric "push button" Hill-Rom Hilow bed sets an entirely new standard for convenience, utility and patient comfort, and is the last word in adjustable height bed design and performance. It is designed so that operation of the Hilow feature and adjustment of the backrest and kneerest may be handled by the patient. As shown above, push button controls for patient use are located on the patient's right—in the seat section of the spring. If such patient operation is undesirable, the nurse can easily make it impossible by the use of "cut-out" switches on the motor unit. All switches are mechanically interlocked—no two push buttons can be operated at the same time. Head end and foot end panels are designed by Raymond Loewy.

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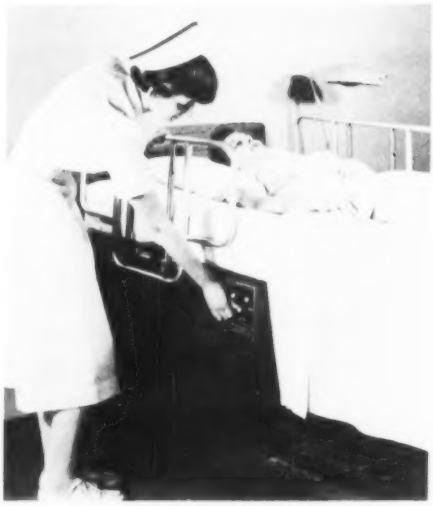

The nurse also finds the push button control panel is conveniently located.

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PROCEDURE MANUAL No. 3

Hilow Beds is the subject of Procedure Manual No. 3, prepared by Alice L. Price, R.N., M.A., Nurse Consultant for Hill-Rom Co., Inc. and author of three leading textbooks on nursing—The American Nurses Dictionary, A Handbook for Student Nurses and The Art, Science and Spirit of Nursing. Copies for student nurses and graduate nurse staff will be sent on request. Address Miss Alice L. Price, Hill-Rom Co., Inc., Batesville, Ind.

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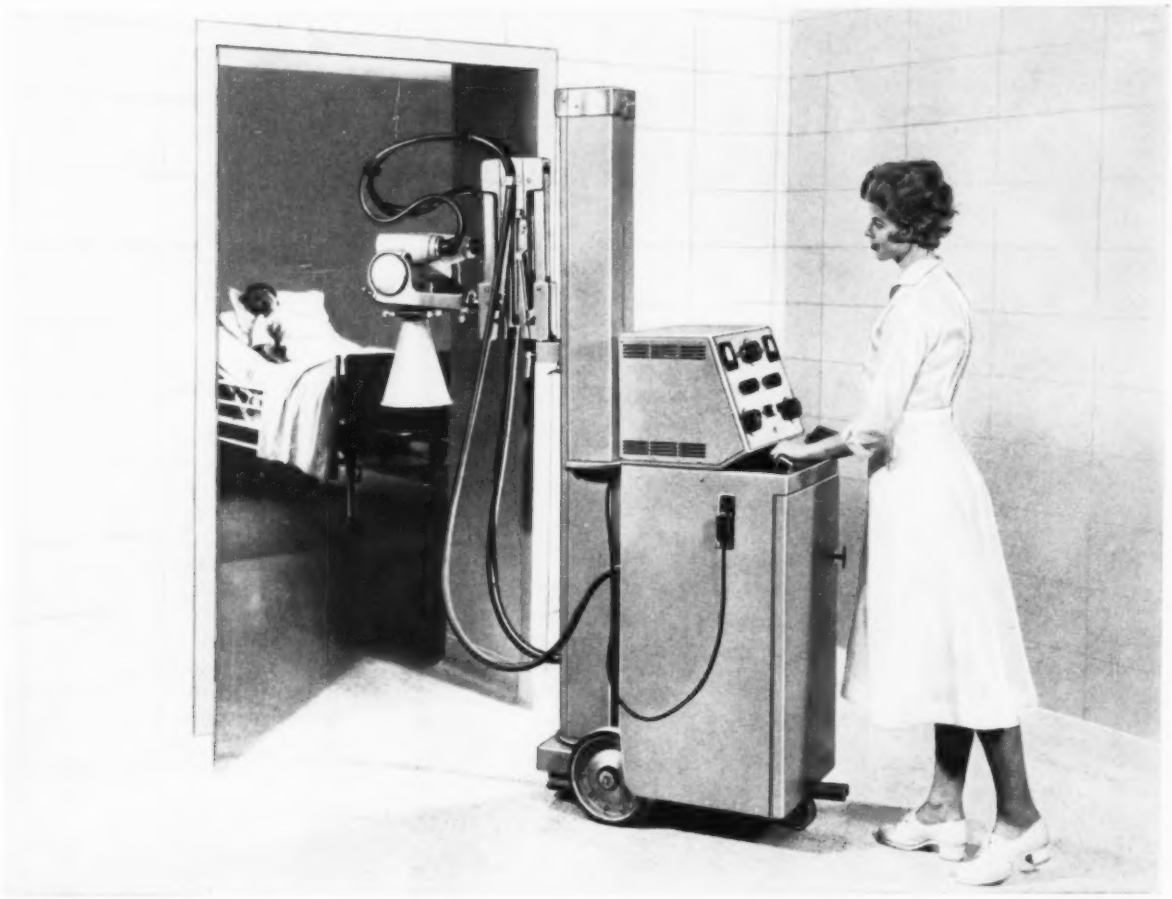

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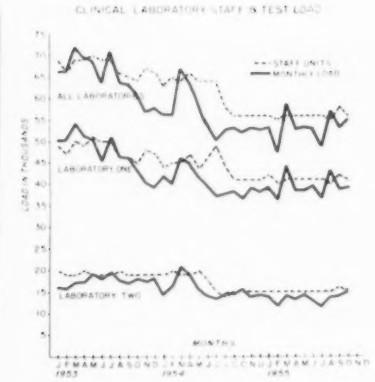

Graph A—Staff and Test Load: This graph on staff and test load shows the adjustments in staff made to suit the expected test load. Laboratory 2 serves the chronically ill patients and needed less staff, space and equipment.

(tuberculosis, paraplegia, neuropsychiatric conditions, and so on).

Reference to Table 3 shows a remarkable coincidence of factors between the two laboratories. Those for chemistry and hematology sections are nearly the same; this tends to support our thesis that whenever tasks done in a section are the same as recorded tests (on the daily work sheet) interlaboratory comparisons are valid. This is further supported by the similarity of the optimum balance factors and the productivity index for these sections. If, however, the tasks and test credits are not similar, tests per man hour is not the sole criterion for interdepartmental comparisons, and the optimum balance factors must be used. The histology sections, shown in Table 3, illustrate this point.

SUMMARY

Up to the present time it has been difficult to evaluate and compare the activities of the various sections of clinical laboratories. Tests per man hour have been shown to be unreliable when used as the sole criterion of comparison between two dissimilar units.

Using our present system of what laboratory activity constitutes a test and calculating, on a percentage basis, the fractional portion of the total laboratory work load done and the time spent for its accomplishment in each section, we have developed two new factors. The optimum balance factor and the productivity index have been used in our laboratory to determine relative deficiencies of the various specialized departments.

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the unbuffered phosphate *complex* of tetracycline

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The Kitchen Was Built for Microwave Cooking

Unsolicited testimonials for institution cooking are the happy result of the installation of microwave ovens and plastic coated paper plates at the Kaiser Foundation Hospital, Harbor City, Calif. A particular advantage of the microwave cooking is the ability to spread the work involved in meeting the mealtime deadline over a longer period of time. The assembling of portions is also accomplished in an unhurried fashion. This 58 bed hospital is planning eventually to expand to 100 beds and by the use of microwave cooking and plastic coated paper plates it is expected that the present staff of seven in the kitchen will be able to take care of the expanded patient load.

E. R. PARK and EVELYN D. IBATA

ONE of the most remarkable features of the new 58 bed Kaiser Foundation Hospital, Harbor City, Calif., is the food service operation, which has been planned around the use of microwave ovens. The patients have told the dietitian that the meals are extremely palatable, and that usually they have to wait for the food to cool slightly before eating. Indeed, this has been quite a reversal from our previous experience in other patient food service operations.

Mr. Park is administrative-dietary consultant, Kaiser Foundation Hospitals, Oakland, Calif., and Mrs. Ibata is head dietitian of the Kaiser Foundation Hospital at Harbor City, Calif., where the food service operation described here is in use.

These extremely satisfactory end results did not come about by chance. During the past several years various staff members of the Kaiser Foundation Hospitals have endeavored to find a better system of food service. Finding that by using microwave ovens we could furnish hotter, more palatable meals to our patients, and at the same time effect economies, it was decided to install such a system in the Harbor City hospital. The floor plan shown here indicates that the over-all space requirements for this type of service are considerably less than those usually required when all conventional equipment is used. Inasmuch as this system involves primarily two assembly lines, all equipment was placed to reduce employes' steps to a minimum.

Plan of the kitchen at Kaiser Foundation Hospital shows that over-all space needs are less for microwave ovens than for conventional type.

An important aspect of this operation is the use of disposable plastic coated paper service. In the past patients had expressed a desire to have their food served on these "one-service" utensils. The plastic coated paper products we use have a smooth unpaperlike surface, hence the customary "paper taste" associated with eating or drinking from a paper item is eliminated. By using paper service, of course, we were able to eliminate dishwashing almost entirely except for silverware and trays. In addition, paper service makes the trays much lighter and

Above: Plastic coated paper containers are stacked on a worktable adjacent to the microwave ovens. Dietary worker places plate of food in the oven; it will be cooked in 40 or 50 seconds. Below: A conventional electric range and small pressure cooker are used for precooking.

easier to handle and coffee stays hotter because there is little heat transfer from the coffee to the cup.

The use of microwave ovens permits us to change one basic concept of institutional food preparation where conventional cooking equipment is used exclusively, namely, that all food must be done by a set time and that all available labor must be concentrated on the task of getting the hot food dished up and transported to the patient as speedily as possible, in order that the food be hot and palatable when it reaches the patient.

Our system, using microwave ovens, involves a certain amount of precooking in the form of blanching some vegetables so that when the cooking is completed on the plate in the microwave oven, the food will have the customary tenderness that people associate with the particular item. Potatoes are completely precooked; meats, generally, are precooked only so that the outer surface is browned, while the inside is usually raw; poultry is generally precooked almost to the final degree of doneness.

The microwave ovens, a small conventional electric range with home-size oven, and a small high-compression steam pressure cooker are used for any required precooking. The precooking of the meat and poultry items is done a week or two before these foods are actually served. Immediately after precooking they are wrapped, labeled and placed in a subzero reach-in freezer, where they are frozen and stored until used. The potatoes and vegetables are precooked to the desired degree of doneness either the same day they are

served or the day before, depending on the item, and kept refrigerated until used. Therefore, we can spread the labor of precooking over the entire eight-hour workday of the one cook employed in the kitchen, and the problem of trying to keep the food hot is, for all practical purposes, eliminated.

At this point one can readily see that we are concerned with assembling this refrigerated food on the patient's plate. A transparent covering is then placed over each plate. These plates are processed through the microwave ovens just prior to being transported to the patients, and the cooking of the food is completed on the plate in a matter of 40 to 50 seconds per plate. The transparent covering is left on the plate until it reaches the patient, to help prevent dehydration of the food while cooking and also to keep the food hot while in transit to the patient. The hot plates are placed in the preheated section of conventional food carts. When the food cart arrives outside the patient's room the hot plate

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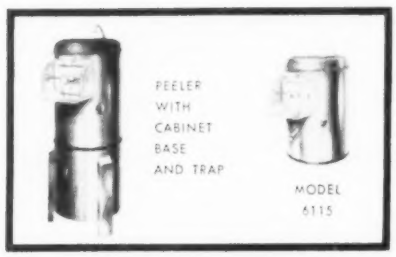

Model 6115 Stainless Steel Portable Peeler. *Finish*—satin-finished stainless steel body, gray plastic cover, cast aluminum door, door handle and chute. *Capacity*—15-20 lbs. in 1-3 mins. Stainless steel cabinet base and trap accessory converts unit to floor machine.

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is placed on the patient's tray and delivered by a nurse or nurse's aide. The total time needed to assemble all the patient plates, process them through the microwave oven, and deliver them to the patients for any one meal is not more than an hour and 30 minutes.

Five dietary employes, plus two relief employes to cover days off, are required to take care of the complete food service operation. The same complement of employes will be able to handle the expansion to 70 beds anticipated in the near future, and also the eventual expansion to 100 beds. This represents a 30 per cent reduction in employes, when compared to one of our other hospitals where conventional food service equipment is used.

This system, which permits unhurried assembling of portions on plates, allows us to effect good portion control, and we have experienced less waste than with other systems. To date our raw food costs average 28 to 31 cents per meal served, which represents a saving of 20 to 25 per cent when compared to some of our other hospitals where conventional equipment and service are in use.

Dietetically, the system has been most satisfactory, for each plate is seasoned after the food is assembled on the plate, in accordance with the diet prescribed for the patient. Therefore, through judicious use of seasonings, we can make all diets more palatable.

Our patients are pleased with this type of food service. The following letters received from two of our patients, are typical of the reactions:

". . . They (the meals) were simply delicious. I would also like to add that I am not alone in thinking this. Many of the other patients, in the maternity ward, commented to me on the delectable meals served, and also the difference from that of other hospital meals. I think that the system you have is about the best I have ever seen or heard of."

". . . One more congratulatory remark—your new method of serving on paper plates, heated by electric ovens, is the idea of a genius, and a most sanitary and effective method of serving meals."

We have every reason to be happy with this system of food service, but at the same time we feel that it offers an even greater potential than has been achieved to date. Each day seems to bring forth more ideas for improving the system, all of which results in more refinements and economies.

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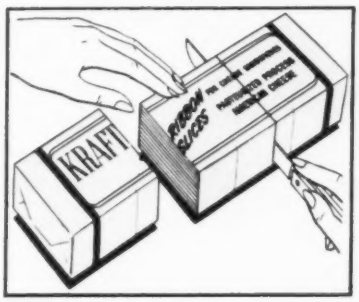

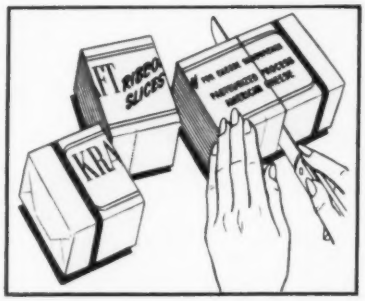

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RED LINES (¾-oz. slices). Cut along red lines to get 64 uniform *cheeseburger* slices—each weighing ¾ ounce.

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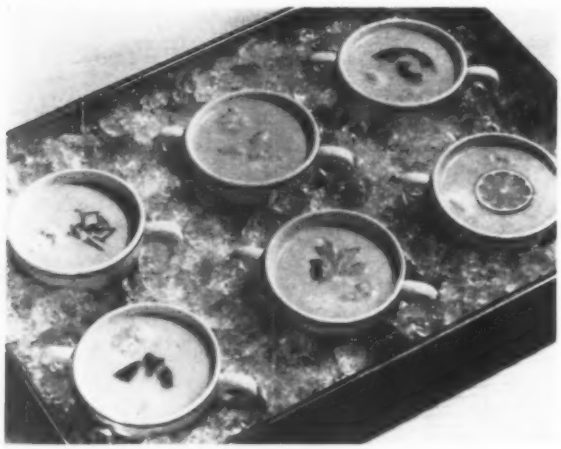
DORIS H. ZUMSTEG
Teaneck, N.J.

SOME patients find nothing to interest them from one meal to the next; thus their food takes on an added importance beyond its nutritional value. For waning appetites, a "different" food many be just what the doctor would order, if he had the time. These suggestions are some simple switches on basic foods. First, there is soup served *cold* and decorated with a variety of toppings. Second, try a recipe for sandwiches that are *fried*.

CHILLED SOUP



Chilled Shrimp Soup

Yield: 25 4-Ounce Portions

5 cans (10 ounce size) frozen condensed cream of shrimp soup
2½ soup cans (3 cups, 2 tablespoons) milk
2½ soup cans (3 cups, 2 tablespoons) water
½ teaspoon monosodium glutamate

Pour ingredients into saucepan; heat until soup is thawed. Simmer gently until smooth. Chill.

Suggested toppings: chopped chives, toasted almonds, green peppers, pimientos, celery leaves, parsley, tiny watercress sprigs, sour cream.

FRIED SANDWICHES

French Fried Beef and Cheese Sandwich

Yield: 25 3-Ounce Servings

3 pounds ground beef
Fat, for frying
1 pound sharp cheese, ground
⅓ cup prepared mustard
2 cups pickle relish
50 slices bread
4 cups (1 quart) salad dressing
Salt, pepper and monosodium glutamate
12 eggs, beaten
2 cups milk
1 teaspoon sugar

Brown beef quickly in hot fat, stirring constantly; let cool. Combine beef, cheese, mustard, relish and salad dressing; mix thoroughly. Correct seasoning with salt, pepper and monosodium glutamate.

Make sandwiches, using 2 slices bread per sandwich.

Combine beaten eggs, milk and sugar. Dip sandwiches in egg mixture. Fry on moderately hot greased griddle or in deep hot fat (375° F.) until golden. Drain on absorbent paper.

To serve, cut each sandwich into 2 triangles. Garnish with sliced fresh tomatoes and a dill pickle half.

Menus for November 1957

By Virginia Rezabek
Head Dietitian
MacNeal Memorial Hospital
Berwyn, Ill.

1 Fresh Pears Sweet Roll • Vegetable Soup Halibut Steak, Tartare Sauce Mashed Potatoes Buttered Lima Beans Pineapple Salad Vanilla Ice Cream • Tomato Soup Welsh Rabbit on Toast Cups Buttered Green Beans Hard Cooked Egg Salad Peach Crisp	**2** Orange Juice Poached Egg • Beef Broth Roast Lamb Boiled Potato Chopped Spinach Spiced Apple Ring Salad White Cake With Lemon Icing • Cream of Mushroom Soup Hamburgers, Buns, Ketchup Potato Chips Relishes Canned Purple Plums	**3** Half Grapefruit Coffee Cake • Chicken Rice Soup Roast Chicken, Giblet Gravy Mashed Potatoes Mixed Vegetables Molded Cranberry and Orange Salad Date Torte • Baked Ham, Pineapple Chunks Acorn Squash Potato Salad Soft Custard, Frozen Strawberries	**4** Blended Fruit Juice Scrambled Eggs • Beef Noodle Soup Roast Beef, Gravy Parsley Potatoes Creamed Corn Tossed Vegetable Salad, Vinegar, Oil Tapioca Cream Pudding • Cream of Potato Soup Chicken Pot Pie Wax Beans Peach and Pear Salad Cherry Cake	**5** Fresh Grapes Sweet Roll • Green Pea Soup Meat Loaf, Mushroom Gravy Mashed Potatoes Sliced Beets Spiced Apricot Salad Raspberry Gelatin, Cookies • Fruit Juice Roast Veal Buttered Asparagus Kidney Bean Salad Orange Ambrosia	**6** Tomato Juice Soft Cooked Egg, Bacon • Chicken Barley Soup Roast Chicken Baked Potato Parsley Buttered Carrots Waldorf Salad Ice Cream • Vegetable Beef Soup Creamed Chipped Beef on Toast Buttered Peas Head Lettuce Salad, 1000 Island Dressing Mincemeat Pinwheels
7 Tangerine French Toast, Sirup • Oxtail Soup Swiss Steak Mashed Potatoes Cauliflower Mixed Greens Salad, French Dressing Grape Bavarian • Cream of Chicken Soup Spanish Rice Green Beans Cottage Cheese Salad, Chopped Olive Garnish Frozen Peaches	**8** Stewed Prunes Sweet Roll • Vegetable Soup Tuna Fish and Noodle Casserole Buttered Spinach Coleslaw, Celery Seed Dressing Baked Apple, Cream • Egg Drop Soup Toasted Cheese Sandwich Tomato Wedges Pear, Currant Jelly Salad Chocolate Ice Cream	**9** Apricot Juice Poached Egg • Beef Broth With Rice Broiled Beef Liver Mashed Potatoes Glazed Carrots Grapefruit-Celery Salad, French Dressing Sponge Cake • Bean and Bacon Soup Cube Steaks Baked Potato Asparagus, Pimiento Salad Fruit Cocktail	**10** Orange Juice Coffee Cake • Chicken Broth Roast Chicken Mashed Potatoes, Gravy Broccoli Crabapple Salad Refrigerator Cheese Cake • Cream of Tomato Soup Ham Salad, Egg Salad Sandwiches Pickles and Olives Jellied Cranberry Salad Vanilla Pudding	**11** Fresh Pear Scrambled Eggs, Bacon • Beef Noodle Soup Short Ribs of Beef Cottage Fried Potatoes Harvard Beets Pineapple, Marshmallow Salad With Sour Cream Apple Tapioca • Grape Juice Italian Spaghetti Vienna Bread Whole Kernel Corn Lettuce Wedge With Bleu Cheese Dressing Cranberry Kuchen	**12** Grapefruit Juice Sweet Roll • Celery Soup Roast Lamb Whipped Potatoes, Gravy Buttered Peas Stuffed Peach Salad Bread Pudding • Consommé Creamed Turkey With Drop Biscuits Asparagus, Cuts and Tips Tomato Aspic Salad Fruit Cup
13 Stewed Apricots Soft Cooked Egg • Beef Broth Chop Suey and Rice Chow Mein Noodles Tossed Vegetable Salad, Vinegar, Oil Chocolate Chip Torte • Tomato Juice Baked Ham Sweet Potato Spiced Pear Salad Cherry Cobbler	**14** Fresh Grapes Raisin Toast, Sausage • Cream of Asparagus Soup Roast Beef Mashed Potatoes, Gravy Breaded Eggplant Sliced Orange Salad Coconut Cornstarch Pudding • Blended Fruit Juice Beef Rolls and Gravy Carrots, Onion Butter Deviled Egg Salad Fruit Gelatin	**15** Half Grapefruit Sweet Roll • Vegetable Soup Broiled Salmon, Lemon Creamed Potatoes Brussels Sprouts Seedless Grapes Salad Meringue Pie • Cream of Corn Soup Baked Macaroni, Cheese Apple and Raisin Salad Gingerbread With Whipped Cream	**16** Tangerine Poached Egg • French Onion Soup Breaded Veal Cutlets Boiled Potato Whole Buttered Beets Lettuce, Dressing Pineapple Upsidedown Cake • Vegetable Beef Soup Baked Beans, Bacon Mixed Fruit Salad Brown Bread Apricot Whip	**17** Orange Juice Coffee Cake • Chicken Noodle Soup Stewed Chicken With Dumplings Green Beans Jellied Vegetable Salad Plum Pudding With Hard Sauce • Cream of Celery Soup Waffles, Maple Sirup Peach, Cottage Cheese Salad Lime Sherbet, Cookies	**18** Stewed Prunes Scrambled Eggs • Potato Soup Roast Lamb Mashed Potatoes Cauliflower au Gratin Grapefruit and Apricot Salad Chocolate Cake • Tomato Juice Hot Beef Sandwich, Gravy Shredded Lettuce, Celery Seed Dressing Royal Anne Cherries
19 Pineapple Juice Sweet Roll • Beef Noodle Soup Ham Loaf Escalloped Potatoes Buttered Peas Perfection Salad Apple Crisp, Cream • Vegetable Soup Roast Veal Wax Beans German Potato Salad Prune Pudding	**20** Applesauce Soft Cooked Egg • Chicken Broth Roast Chicken Mashed Potatoes Buttered Parsnips Lettuce Salad, Dressing Ice Cream • Cream of Mushroom Soup Salisbury Steak Buttered Lima Beans Spiced Peach Salad Angel Food Cake	**21** Banana Poached Egg • Consommé Lamb Stew with Potato and Vegetables Fall Fruit Salad Butterscotch Pudding • Vegetable Juice Link Sausage Baked Sweet Potato Coleslaw, Oil Dressing Kadota Figs	**22** Grapefruit Juice Scrambled Eggs • Clam Chowder Breaded Perch, Tartare Sauce Whipped Potatoes Broccoli Pear, Grated Cheese Salad Fruit Pie • Vegetable Soup Salmon Roll, Cream Gravy Sliced Carrots Tomato, Lettuce Salad Cranberry Sherbet	**23** Sliced Orange Poached Egg • Beef Barley Soup Roast Beef, Gravy Parsley Potatoes Asparagus Vegetable Salad, French Dressing Graham Cracker Pudding • Apple Cider Lamb Chops Spinach Cottage Cheese Salad Fruit Cup, Cookies	**24** Fresh Grapes Coffee Cake • Chicken Noodle Soup Fried Chicken Mashed Potatoes Whole Kernel Corn Celery Pinwheel Salad Pineapple Delicious • Scotch Broth Sliced Ham, Swiss Cheese Sandwiches Potato Chips Relishes Chocolate Frosted Cupcake
25 Blended Fruit Juice Soft Cooked Egg • Beef Broth Beef Stew, Dumplings Head Lettuce, French Dressing Orange Cake • Grapefruit Juice Canadian Bacon Candied Sweet Potato Spiced Apricot Salad Fruit Gelatin	**26** Tangerine Sweet Roll • Chicken Noodle Soup Roast Lamb Creamed Potato Buttered Peas Jellied Fruit Cocktail Salad Banana Vanilla Pudding • Peach Nectar Spaghetti, Meat Sauce Spinach Tossed Green Salad, Vinegar, Oil Baked Apple, Cream	**27** Orange Juice Scrambled Eggs, Bacon • Beef Rice Soup Roast Rib of Beef Mashed Potatoes Baked Squash Pineapple Salad With Date Garnish Crumb Cake • Cream of Pea Soup Chicken Turnovers, Gravy French Green Beans Stuffed Prune Salad Molded Custard, Frozen Raspberries	**28** Half Grapefruit French Toast, Sirup • Consommé Roast Turkey With Dressing Mashed Potatoes, Giblet Gravy Creamed Onions Cranberry Sauce Relishes Pumpkin Pie • Cranberry Cocktail Ham Baked Sweet Potato Mixed Fruit Salad Fruit Cake	**29** Stewed Apricots Sweet Roll • Cream of Mushroom Soup Baked Haddock, Lemon Boiled Potato Beets Orange, Grapefruit Segment Salad Vanilla Ice Cream • Vegetable Soup Tuna Fish and Egg Salad Creamed Potato Asparagus Baked Custard	**30** Tomato Juice Poached Egg • Beef Broth Ham Noodles Cauliflower au Gratin Shredded Lettuce, Salad Dressing Fruit Cup • Cream of Celery Soup Cold Sliced Turkey Baked Potato Fried Apple Rings Jellied Mandarin Orange Salad Caramel Pudding

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An Efficient Laundry Is Equal Parts Good Equipment and Good Management

EDWARD LUCAS

EQUIPMENT plus good management mean money saving efficiency for the laundry department of the Swedish Hospital in Seattle. Comparative figures since the installation of the hospital's new laundry room in 1955 show an improvement in efficiency that would make a respectable showing on any hospital manager's budget. Administrator R. F. Farwell is correspondingly happy with the results achieved.

"We spent about $85,000 on new equipment for the laundry, and it's worth every penny of it," says Mr. Farwell. "We knew it was necessary in any case in order to take care of our expanded hospital facilities at Swedish, but the improvement has been even better than we expected.

"Our expansion program meant a corresponding load increase for the laundry of 15 to 20 per cent. The reconstituted laundry department has not only taken that increase in its stride, but has reduced total operating costs by $1300 to $1500 per month. I'd estimate we save more than $2000 a month over costs of operation under that much load with our old laundry."

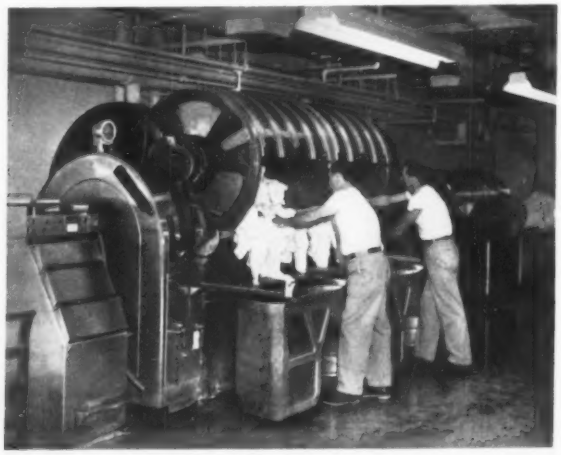
New equipment is only half the story, Mr. Farwell points out. Good management is required to make the best laid out laundry pay its way. The second principal improvement at Swedish dates back to July of 1955, when John R. Horrigan took over management of the laundry.

"Since Mr. Horrigan took over," according to Mr. Farwell, "the number of laundry employes has been reduced from 29 to 21, which accounts for the principal saving. At the same time, linen delivery service to the floors has improved. And our average laundry load has gone up from about 29,000 to more than 35,000 pounds per week."

Except for obstetrical, surgical and nursery linen, soiled laundry is delivered by chute and conveyor belt to a corner of the laundry room, where it is sorted and put into carts to be rolled to the washers. The main units there are two 42 by 84 inch unloading washers with automatic controls and one 42 by 72 inch washer with manual controls. One 24 by 36 inch pony washer is used for smaller batches.

Extracting is handled by one 54 inch extractor and one 30 inch solid curb extractor. Shake-out is done in a 200 pound capacity tumbler with loading hopper. Drying tumblers include one

Wooden sorting carts with high backboards, shown at left, were designed for dry sorting of clothes. More breakdowns at dry sorting have increased production.



Two laundrymen unload one of the automatic washers. There are two large (42 by 84 inch) automatic units, one 42 by 72 inches, manually controlled, and a "pony" size.

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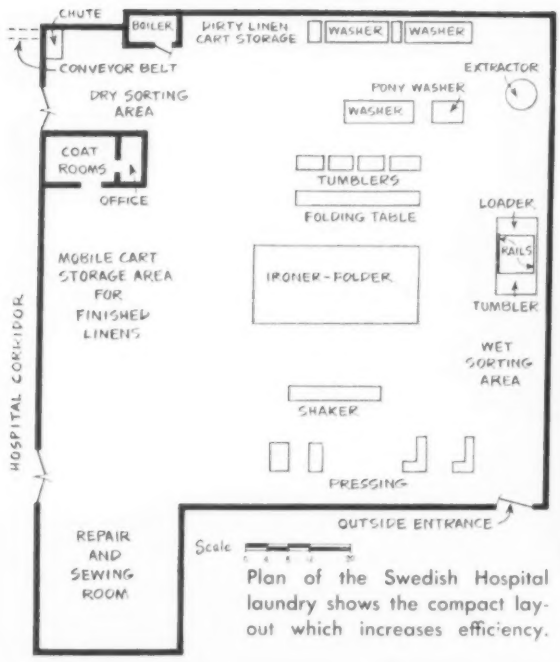
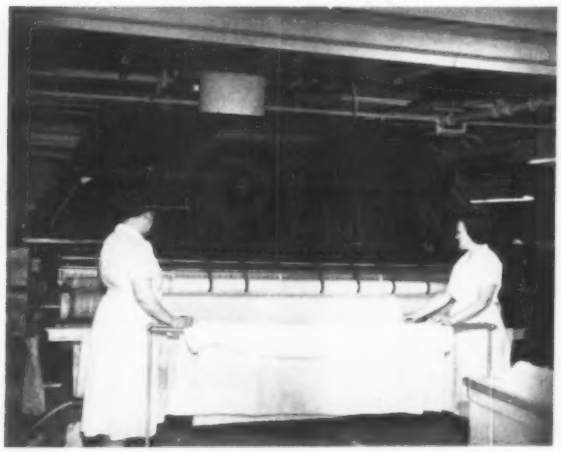


Plan of the Swedish Hospital laundry shows the compact layout which increases efficiency.

Clothes are routed from washers to extractor. Here, extracting has been completed, and clothes are ready to be dumped into loader, which puts them in the tumbler.



The sheets are fed into ironer-folders such as this one. This 10 foot ironer can be either one or two-lane. Here it is one-lane, since sheets are more than 5 feet wide.

At discharge end of ironer-folder, finished items are finish-folded, if more folds are needed, and placed in cart at back. Two women perform this laundry operation.

new 44 by 42 inch machine and three 36 by 36 inch tumblers reconditioned from the old laundry.

The biggest and most expensive piece of plant equipment is the two-lane, eight roll ironer and folder, installed at a cost of nearly $30,000. Other equipment includes a sheet spreader and new press units.

A general change required when the new equipment was installed was the appointment of a floor woman to supervise the finishing end of the work. The washing and drying are supervised by the chief washer. While this meant an immediate small increase in labor cost, it has resulted in closer, more efficient supervision.

Immediate expenses were also increased by an expenditure that was needed to set up smoothly operating work procedures. That was expansion of the hospital's linen inventory.

"The hospital used to operate with only two and one-half changes per bed," John Horrigan, the laundry manager, explains. "The result was that floors were continually running short on linen, requiring special rush jobs of certain items. It was plain to me that we could not follow the routines necessary to reduce our labor costs if they were going to be frequently interrupted for special work."

He bought time for the laundry by increasing the linen inventory to four changes per bed. Besides making efficient operation possible, he believes it has contributed to the longer life of the linen. Replacement cost per bed now runs at the below average rate of 19 cents per bed per day. The greater inventory also permits them to operate on a 40 hour week of Monday through Friday for the laundry as a whole.

One of the manager's improvements was to increase the number of break-

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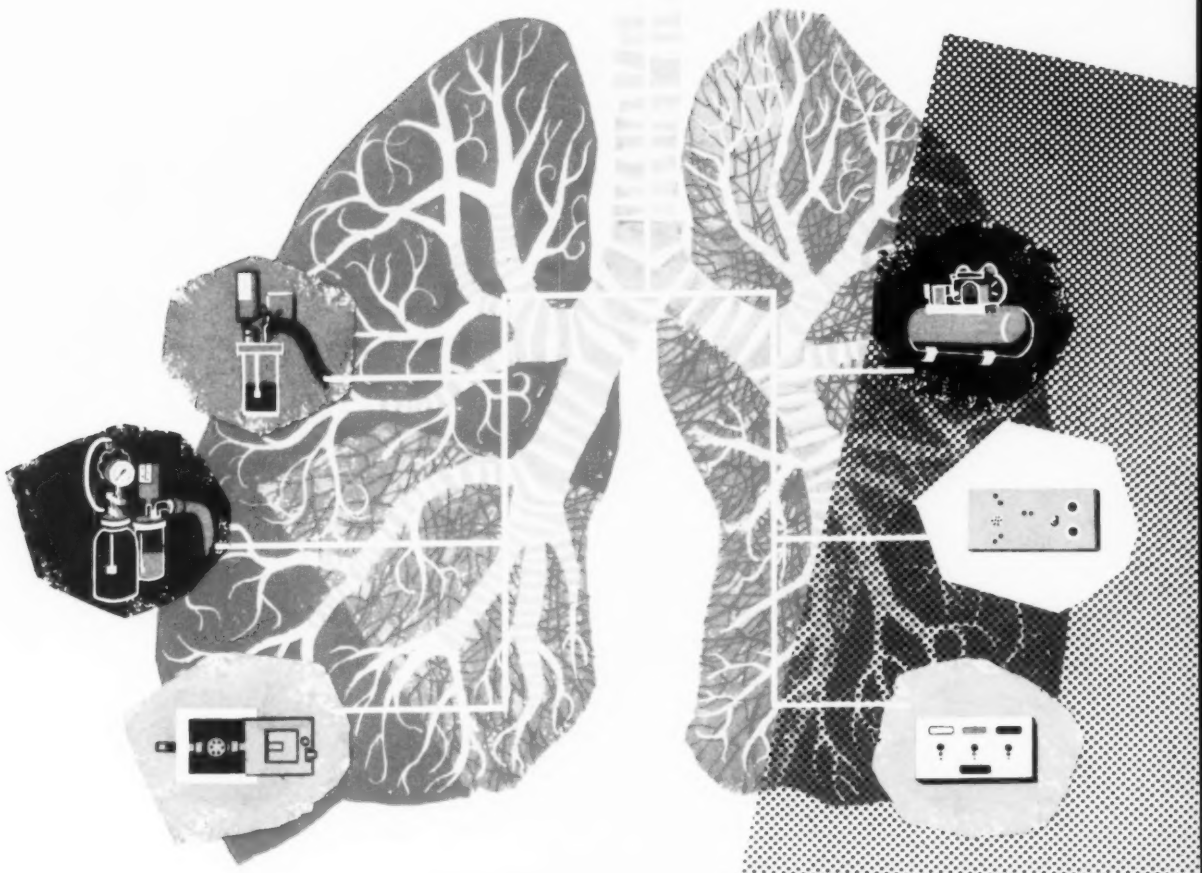

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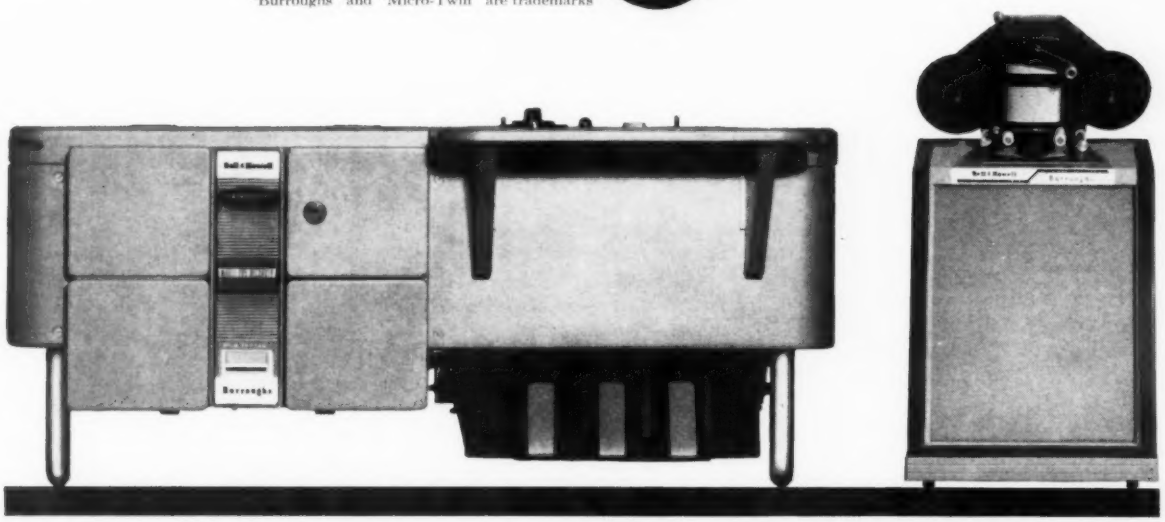

Left: Loading delivery cart. Right: Storage carts hold backlog of floor linen.

John Horrigan, laundry manager, talks over problems with floor woman.

downs in dry sorting. Where unstarched linen was formerly sorted into only three classifications, it is now broken down into six categories: (1) draw sheets, (2) bath blankets, (3) sheets, (4) tumbled laundry, (5) gowns and (6) small pieces, such as face towels, pillow slips, stand covers, binders, dresser scarves, and so on.

The main advantage here is that these items are much easier, lighter and faster to handle when dry. Further dry breakdowns would be made if sufficient quantities were required to make full washer loads.

Other items that are dry-sorted are uniforms and other starch work, blankets, and colored bedspreads. Linen from obstetrics, surgery and nursery is handled separately and sorted after washing.

Sorting has been further expedited by special sorting carts built to Mr. Horrigan's specifications, with high plywood backboards against which items are thrown by the sorter. Enough linen carts are on hand so that all soiled laundry can be wheeled over to the washers.

Getting the best out of the equipment in many cases is done by tightening up certain operational details, the laundry manager observes.

For instance, 54 inch surgery wrappers used to be fed into the flatwork ironer by two feeders in the same way as bed sheets. Since wrappers are only 54 inches wide, Mr. Horrigan determined that they could be handled by only one feeder without difficulty, and that they would not have to take up more than one side of the 120 inch wide ironer. This left the other half of the two-lane ironer for other work. The change was made satisfactorily, and production of wrappers has doubled.

Again, he found that bath blankets, draw sheets, and plain sheets were being fed unsorted into the ironer. This required that the ironer speed for all of them be set at the 55 to 60 feet per minute speed required for the slower draw sheets and bath blankets. By presorting them Mr. Horrigan stepped up the speed for sheets to a steady 80 feet per minute.

Another item, surgical trousers, had been put through the ironer spread flat, belt first, with the folder on bypass. Nevertheless, the belt strings would occasionally catch in the conveyor ribbons, causing a temporary shut down. At the receiving end, too, the folders had to make five motions to fold trousers fed in this manner.

CHANGE OFFERS ADVANTAGES

Now, the trousers are tumble-dried a little longer and fed into the ironer sideways with the legs folded together and the belt strings inside the fold. This change has resulted in three advantages: (1) Two pairs of trousers can be fed into each lane in the same space that one pair used to require, spread flat; (2) the hidden strings no longer catch in the conveyor ribbons, so that shut downs from that cause are eliminated, and (3) the women receiving the trousers can make the same fold with two motions instead of five.

Time also has been saved on the receiving end of the ironer-folder, where two women formerly worked when they were running sheets. This was considered necessary to make a precise finish fold, but Mr. Horrigan disagreed. He was, he considered, laundering for a "captive" customer whom he did not have to impress with a precision job of folding. Now one woman handles the work and does a speedier, less exact, but thoroughly satisfactory job.

A similar concern for making the most of his equipment led the manager to two improvements in opera-

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tion of the extractor. Only one hoist was used at first here, and Mr. Horrigan noticed that the extractor was idle for about five minutes while the laundry from one load was being transferred by hoist to the shake-out tumbler. Repeated a number of times a day, that added up to a good deal of shut-down time for the extractor.

Correction was made by installing a second 1 ton hoist. Now, the metal baskets with the extracted load are lifted out of the extractor, and the next load from the washers is lifted into it. The first load is then taken over and dumped into the shake-out tumbler while the extractor is working.

The second improvement was the painting on the wall of three black lines spaced about 4 inches apart, one above the other, each line being perfectly horizontal as determined by a spirit level. This enables the extractor operator to balance the baskets perfectly, checking their own level visually against the lines. It also assures better operation of the extractor.

At Swedish Hospital, the laundry department is responsible for collection of dirty linen and dispensing of the clean. Better organization has reduced the number of people required for dispensing from three, to about one and one-half.

One reason for the labor saving is that here, as in other phases of the work, Mr. Horrigan has put everything he possibly can on wheels. Storage carts on wheels are positioned just back of the discharged end of the flatwork ironer, and are loaded by the folders as the work comes off the machine. When full, the carts are pushed to the storage area against a wall, where they serve as storage shelves until their laundry has been transferred to the "delivery" carts. The same method is used to load work from the press section.

A FORM LISTS LINEN NEEDS

To supply the floors, Mr. Horrigan has worked out a daily linen requirements form that is duplicated and used for each floor or hospital department every week. The form has space for a "standard," or quantity determined for each item for each department, indicating the quantity that should be in the linen closet to ensure a good day's supply. Linen stocks for the departments are filled by taking a full delivery cart to a department and replenishing stocks of each item to the amount of the standard.

The amount taken is marked down on the sheet for each item every day. The form provides both a record and a systematic method of assuring that all hospital departments are adequately stocked every day.

The only exception to this routine is laundry for OB, surgery and nursery. This is loaded into delivery carts from the flatwork ironer and taken directly to the appropriate departments.

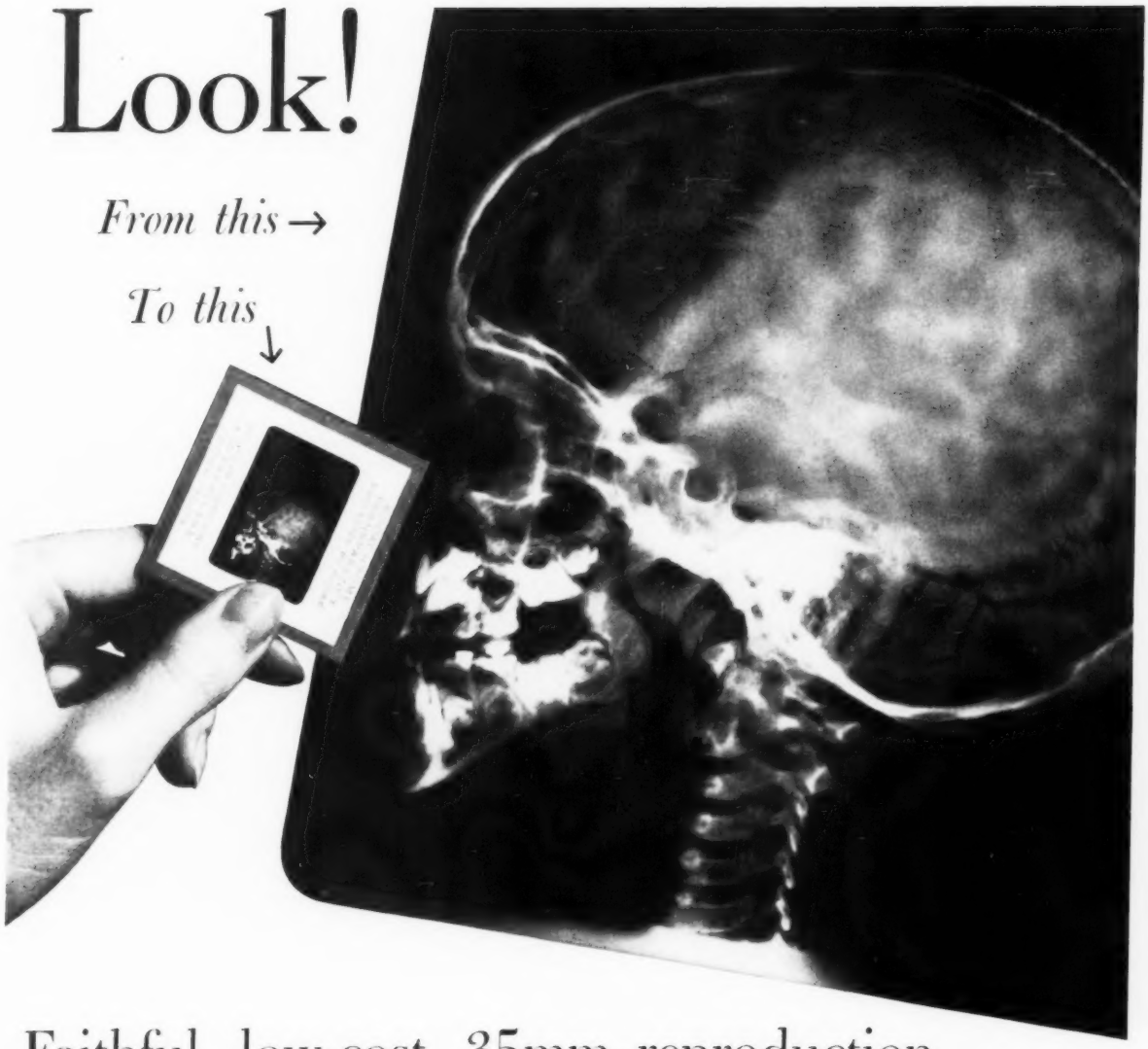
At appropriate points in each department, recesses have been built into which storage carts on wheels can be pushed. Fully loaded carts are wheeled to each department, where they are exchanged for the nearly empty storage cart from which that department has been drawing its linen supplies. That cart is wheeled to the basement for reloading and delivery the following day. Handling is thus kept to an absolute minimum.

The only week-end work that must now be done by this department is collection of dirty linen. One man takes care of this on Saturday and Sunday, plus production of three washes on Sunday to start the finishing crew on Monday morning.

Look!

From this →

To this ↓



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A Training Program for Housekeepers

8. Make the Best of Your Budget

BARBARA D. MILLS

HAVE you ever built a house? Have you ever thought about building anything? If you have, you know that first you had to make plans which in turn were drawn by an architect who understood the problems of building.

You, as an executive housekeeper, are the architect for the structure of the housekeeping department and so must be ever watchful for the robbers that play havoc with costs. You should be the one to whom administration can look for any assistance regarding the financial operation in this department.

In discussing this subject of financial control I should like to stress the need to develop your records as simply as possible. Plan them to fit your needs but avoid recording unnecessary details. Here again we find the importance of simplicity, the consolidation of facts and figures so that your records and inventory controls offer data "at a glance." Cost control is one of the best methods to help you operate your department more efficiently and effectively. Also, it certainly is a way in which you can make yourself a very valuable employe.

Important as control may be, it should be clearly understood that it is not the only approach to the treatment of the situation at hand. It is one method, a highly significant method, of dealing with the large majority of waste problems; however you should be fully aware that preventing waste is far from being a one-man job. You must enlist the cooperation of all hands. In order to be an effective "watch dog" of the costs you must first accomplish four jobs, all of which you have had in your training:

1. Observe the causes of waste—materials, condition of equipment, and use of manpower.
2. Establish plans or procedures to eliminate waste.
3. Standardize supplies and equipment.
4. Train your employes and delegate responsibility for follow-through.

If you attack your waste problems in this manner, you soon will realize a sharp cut in costs.

1. Be ever alert to the fact that most jobs can be improved by work simplification.
2. Develop procedures that will reduce the work load, which in turn will enable you to reduce your manpower.
3. Establish accurate guides for purchasing. This is your most effective way to standardize supplies and equipment procurement.
4. Make reduction of costs a reality on the budget or expense reports by following through.

HARD TO GET COOPERATION

A preventive maintenance program, of course, is one of the important methods of waging a systematic campaign against waste. Housekeepers are still having difficulty in obtaining cooperation with this type of program. True, we talk preventive maintenance, and the housekeeping division can help by reports of needed repairs found during inspection rounds.

However, in most instances the maintenance department has no such program established or it has only recently established the program, and the accumulation of years of wear and tear makes for a terrific job. Apparently this situation stems from the fact that none of its personnel has sufficient time to give our inspection reports consideration. If the preventive maintenance method had been adopted when the institution was in the blueprint stage, daily maintenance would be at a minimum, except for the unpredictable breakdowns.

Yes, I know. Your detailed reports usually mean you are made to feel like the "head of an international spy ring," with a reputation of being "too darn nosey." Well, you must stand for such criticism for the results you produce: the patients' well-being and, in many cases, prevention of emergencies.

If you are to approach the basic functions of cost control correctly, it will be necessary to do three things: (1) Set up cost cards on each item (file as related to budget allotments); (2) Get the cost for each of these items (note price bracket); (3) record costs, outlet, budget coding and quantities of items purchased throughout the fiscal year.

You seem quite perplexed. I see frowns, and that "says she" attitude seems to prevail. What is the meaning behind this? Let's get your thinking out in the open for discussion.

1. How can you know when you are saving money or doing things for less if you never see any figures or records?

(*Continued on Page* 128)

Mrs. Mills is director of housekeeping services, St. Luke's Hospital, Chicago. This article is the eighth in a series. Next month Mrs. Mills will discuss decorating and laundry.

(Items of great Interest)

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(*Continued From Page 126*)

2. Many hospitals don't even bother to include the housekeeping department in the budget. It just gets what's left after the requirements of other departments have been filled.

3. The housekeeper gets little, if any, thanks for trying to suggest the purchase of a less expensive item which she thinks would serve just as well. Usually the treatment is one of ignoring the entire suggestion or implying that our ignorance is so vast on the subject of buying that it will be "taken under advisement." In most instances "under advisement" means it is pigeonholed and you just don't need to bother to come back.

Many institutions fail to create interest in cost control because their department heads never have the opportunity to approve bills and to see just what their department's operation costs are. Accounts payable are handled in various ways but one thing is *sure, i.e.* you must make some type of a "request to purchase" to get the items purchased to meet your needs. Keep a copy of this request. When you sign the bill of lading or receiving ticket of merchandise received, pull your copy of the "request to purchase" and, if quantities ordered and received agree, post the following: quantity, cost, from whom purchased, date of merchandise received, and the quantity price bracket if one is indicated.

I suggest that periodically you should check costs so that your records will be up to date on price changes. Pennies add up to dollars over a period of time and certainly would influence your cost of operation. Effective purchasing is sound management. (The budget coding I will discuss with you in detail when we take up the matter of budgeting.)

After one year of keeping costs of operations you will, of your own volition, automatically make plans for less costly procedures and therefore establish a goal which you will strive to obtain. This is the sort of thing that makes your job interesting: to see the quality and quantity of service *increase* and the cost *decrease*. Remember, you can always pay off a machine but never manpower.

Let's take a simple example: How do you find out how much money you need for cleaning supplies for a year throughout the patient areas?

1. Determine quantity of detergent or cleaner *assigned weekly* to one area.

2. Determine quantity of other cleaning supplies used in an area that are exchangeable, such as paste cleaner, scouring powder, wet mops, dust cloths, dust mops. These should be figured on the basis of how often they are replaced.

For instance, a can of paste cleaner may be brought in on every supply day, but it is only half empty. We have found that this is the usual procedure; thus the floor or area uses only 1 pound paste cleaner for 26 weeks or 26 lbs. times cost per lb. = total cost *per year* for paste cleaner in that area.

3. Add cost of detergent and average cost of cleaning supplies used in area and you have the cost *per week*.

Figures for St. Luke's Hospital (580 beds) should look something like this for the large wards per week.

Detergent or cleaner (2 gallons)	$3.00
Other supplies (cleaning)	2.36
Total	$5.36

This, of course, does not include cleaning equipment, such as mop handles, dust pans, aide carts, buckets, wringers, toilet and radiator brushes.

brooms, vacuums and floor machines. This type of equipment is usually considered as capital stock and is discounted over a period of years.

Most of us are interested in the cost of floor care. Suppose you are taking over an old hospital with floors in bad condition and you would like to establish your cost for the first year, which would include the cost of getting the majority of these floors in shape for systematic maintenance.

First, either from records already established or from blueprints, you must find the total number of square feet in your hospital *as to building*.

Second, break this figure down to the square feet of various types of floors such as terrazzo, cement, asphalt tile, rubber, vinyl, conductive, marble (domestic or Italian), quarry tile, brick, and so on. This will give you the total square feet requiring wax and the total square feet not requiring wax.

Third, figure the total quantity of detergent, wax, sealers, wool pads, brushes and equipment for machines and anything else pertinent to the cleaning and care of your floors.

For the sake of discussion, let's take these imaginary figures: Total square feet for entire hospital is 429,900 sq. ft.; 429,900 sq. ft. require detergent or cleaner; 96,000 sq. ft. require waxing, pads, sealers.

Detergent or cleaner—	
54 drums (55 gal.)	**$3,500**
Waxes—5 drums (15 gal.)	**500**
Wool pads—all grades and sizes	**280**
Sealers (penetrating)—	
5 gallons	**27**
	$4,307

The total cost of detergent is $0.008+ per square foot, based on 429,900 square feet and the total cost of wax is $0.008+ per square foot, based on 96,000 square feet. Then your total cost per square foot is $0.01 and a fraction. Of course, you have not taken into consideration that other departments were using considerable quantities of the detergent. Nor does this include labor or equipment. We are trying to determine our budget needs for cleaning supplies only, not equipment. You do this throughout all areas in all phases of cleaning and you will come up with the approximate amount to be requested next year.

Wages are figured separately on your budget. However, if you want the over-all figure for your records, you add the cost of labor to the total expenditures for the year and this gives you the actual operating costs. Naturally, your second year will not be as costly for most of the floors that were in poor condition will have been rehabilitated.

I like to shoot for a figure of $0.005 per square foot. This figure is usually hammered out on the anvil of experience. However, when one maintains this figure she has arrived in the maintenance and care of floors. I should like, as the voice of experience, to give you some sound advice, *i.e.* the *initial* cost is not always the *outstanding factor* in purchasing. Good products and equipment may cost more at the beginning, but durability and performance may bring the maintenance cost way below the average and therefore save not only by reducing the amounts needed but in manpower hours as well.

Good products, good equipment, an effective, systematic maintenance pattern are the only ways to keep abreast of the never-ending drive to cut down on costs. However, *never* let your striving to attain a cost goal come before a job well done.

How did I get those figures for cleaning costs? You mean you don't

Fig. 1—BUDGET WORK SHEET FOR 1957—SUPPLIES AND EXPENSE

Department Housekeeping

Patient Areas	Budget 1955	Actual Expense 8-31-56	Estimated Expense 1956	Budget 1956	Referral Nos.	Budget Requested 1957	Budget Allowance 1957
Private HE1P or (700E)	$ 860.14	$ 425.00	$ 625.00	$1,000.00		$1,500.00	
Semiprivate HE1P or (701E)	676.10	395.76	501.50	900.00		900.00	
Wards HE1W	1,500.00	2,550.00	3,500.75	1,500.00		2,100.00	
General HE2G	4,500.00	3,905.75	6,575.10	4,000.00		4,000.00	
Special Services	6,500.00	4,100.65	6,500.00	6,900.00	4	6,900.00	
Repair of Equipment HE4	75.00	500.00	700.90	150.00		500.00	
Miscellaneous	50.00	57.90	85.50	35.00		100.00	
Uniforms UNE2	1,500.00	1,200.50	1,475.50	1,750.00		200.00	
Nurses' Residence							
Supplies and expense NRE1	1,500.50	1,000.00	1,800.50	1,600.00		2,500.00	
Repair of equipment NRE2	1,800.50	2,200.00	3,100.80	2,500.00	1	5,000.00	$2,000.00
Linen and bedding NRE3B	4,000.00	4,500.00	6,500.75	4,000.00		4,000.00	
Miscellaneous	500.00	50.00	75.00	300.00		300.00	
Upholstery Department							
Supplies and expense—UP1	900.50	400.75	570.00	800.00	2	1,000.00	
Slipcover material	120.75			250.00		500.00	
Drapery and curtain material	350.00	50.00	90.00	250.00		500.00	
Upholstery materials UPE5		400.00	690.00	250.00	3	500.00	
Repair of equipment				50.00		50.00	
Window shade material	1,000.00			1,500.00		1,500.00	
Mattress and pillows LRE2B				3,000.00	5	4,500.00	
Blankets				4,200.00			
Building and Grounds							
Patient MBE2P	3,000.00	1,000.00	1,500.00	3,000.00	6	5,000.00	
Other MBE2G	3,000.00	2,000.00	4,500.00	2,000.00	7	2,000.00 5,000.00	

know which figures go into what! All right, let's take the figures for the detergent. Divide the cost—$3500—by the total square feet—429,900. To make life simple, cut off the last two zeros of both figures and bring your decimal point up 2 figures. It will look like this: 35.00 ÷ 4299 = $0.0081+. The wax would be in addition to the detergent, of course, because all floors are washed regardless of covering. Therefore the total of the last three figures in your total quantities, $807.00, would be divided by 96,000 square feet. And you, of course, cut the zeros just as we did before.

With this as a premise we will delve into the presentation of a budget. A budget framework is necessary to operate any division of the hospital and usually consists of three major parts: salaries, supplies and expense (new equipment). Our general cry is "I am just no good at figures!"

This is a poor excuse for a lazy mental attitude that results in failure to understand the value of this most effective management tool. Administrative housekeepers must learn to make these connections between the budget and cost of operations if they hope to succeed in selling top management, which usually has to be convinced economically on the housekeeper's ideas of expenditures. Your mental attitude toward this should be one of keen interest for, apart from its given purpose, a budget can be a fascinating new adventure in creating, stimulating and developing ideas that will help you produce a well planned cost reduction program that can be made a reality on the yearly financial report.

Numerous technics are used for recording the budget. There are forms designed with a coding analysis to represent the various divisions of expenditures throughout the organization. Also there is the individual budget in which the framework is prepared by each department head and which thus spells out the coming year's expenditures and needs for each particular department. The latter is far from realistic or useful as a management tool.

Budgets usually are prepared by those responsible for financial operations and presented to department heads as a means to alert them on their spending as well as give them plenty of time to prepare next year's needs to meet the deadline for the budget. However, if a budget has not as yet been established for your department then you should establish a simple form which you can present each year to show a report of your department expenditures. This takes a little doing because you must audit all your figures, such as payroll, cost of equipment pur-

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Fig. 2—BUDGET WORK SHEETS FOR 1957—NEW EQUIPMENT

Department Housekeeping

Quantity Needed	Exact Description	To Be Located	Date Needed	Approximate Cost	Reference	Budget Allowance Year
HE4 19 only	Buckets, 16 quart white galvanized with casters (@ $7 each	Wards and special areas	1/29/57	$126.00	4	
HE4 19 only	Wringers, galvanized #14 (@ $5.60 each	Wards and special areas	1/29/57	180.00	4	
HE4 2 only	Housekeeping aide carts with carriers for disposal, linen and cleaning equipment (@ $72.50 each	Private patient areas	1/29/57	144.50	4	
LRE2 15 doz.	Pillows, gray goose 21 inch by 27 inch blue and white ticking (@ $6.50 each	Private and semiprivate	1/29/57	$1,170.00	5	
MBE2P & S/P 50 only	Footstools, metal, silver mist	Private floors A-B-C-D	1/29/57	To be determined	6	
MBE2P & S/P	Lamps, bed, Luxo #18518 ivory (@ $16.46 each	Private floors A-B-C-D	1/30/57	$1,415.56	6	
MBE2G	Floor covering Rubber, pattern #1296 Vinyl, second choice, #32994	Cafeteria and hall	3/1/57	To be determined	7	

Fig. 3—BUDGET WORK SHEETS FOR 1957—SALARIES AND WAGES

Department Housekeeping

1	2	3	4	5	6	7	8	9	10	11	12	13
							Annual Salary				Approved Budget Allowance Year 195	
Scale No.	Position No.	Vac. Code	Employe's Name	Exact Budget Title	Date Employed	Date Assumed Present Position	Current Rate	Approved 195 Budget	Requested Year 195	Key to Notes	Date Effective	Annual Rate
#1	106-3 1		Peggy Woods	H. K. aide	6/5/57	6/5/57	$ 77.00		$ 82.00			
#3	106-9-5		John Martin	Houseman	1/23/56	1/23/56	$115.00	$110.00	$115.00			
#2	106-9-15		Clark Robins	Floor mechanic	11/10/56	7/10/57	$120.39	$105.00	$125.39			
#1	106-14-3	14	Jean Shaw	H. K. aide	6/1/57	6/1/57	$ 77.00		$ 87.00	#1		

AIDES: Starting salary—$77 biweekly, with $5 increment every six months for 3 years.
HOUSEMEN: Starting salary—$100 biweekly, with $5 increment every six months for 3 years.
FLOOR MECHANICS: Starting salary—$115 biweekly, with $5 increment every six months for 3 years.
(Robins came in as a houseman, and transferred to Floor Mechanic 7 10 57)

Note 1: Jean Shaw was employed as a vacation relief. She has excellent potential and I wish to make her a late check-out aide, working 1 p.m. to 9 p.m.

chased, and so on, but it is well worth the effort to see how you are producing.

Owing to the limitations of the printed page, presenting all types of budget is impossible. Therefore our attention will be focused on the budget that requires a detailed breakdown of expenditures with coding established for use throughout the organization. The extent of such breakdowns should be in accordance with the business practices of the organization. For the sake of discussion I have made sample budgets for supplies and expense and salaries. After you have looked them over let us discuss them and I will try to clarify anything that is not entirely clear. (See Fig. 1, page 130.)

First you must be guided by the working or fiscal year of the organization—when does it start and finish? This particular budget is set up to cover operations from January 1 to the end of December. As you will note, the supplies and expense budget shows operating expense broken down into various categories within a specific area, such as hospital (patient and general), buildings, bedding, nursing residence, upholstery shop, and so on.

These categories are denoted by a symbol, either a combination of letters and numbers or a grouping of letters that together with their legend are selected by those responsible for establishing financial reports. This coding will guide you as to what type of expenditure can be charged to that particular division of the budget. Furnishings can be charged to certain codings, while only the *repair* of *furnishings* can be charged to another coding.

The referral numbers in the reference column direct attention to your explanation regarding that particular figure. Since most organizations charge off new equipment separate from supplies and expense, it is necessary that you show on a separate sheet your

detailed accounting of new equipment requested. Your additional needs in supplies and general expense would be outlined in detail on another sheet. Therefore, when you issue your referral numbers be sure to keep them in sequence or consecutive order with relation to the division in which they belong.

For example, consider all items requiring an explanation under *supplies and expense*. If there were six items requiring an explanation then there would be six referral numbers running 1 to 6. When this budget for supplies and expense was completed you would start with the next number, which would be 7, for a referral number to explain the needs for *new equipment*. These numbers would range from 7 to 10 or whatever you required to outline your requests. Also, if you had six different items which controlled the increased budget figure and were also reflected in the increase of the one budget figure, all of the six items would bear the same referral number.

The first four columns of this budget form are filled in as follows:

No. 1—Your actual expenditures for the previous year. They could be over or under your request for last year.

No. 2—Cost of operation at the three-quarter mark of your working year.

No. 3—An expression, percentage-wise, in relation to the above figure. What they think your expenses will be by the end of the year.

No. 4—Your requested budget for the present year.

No. 5—This column would be empty and ready for your figures for the coming year.

No. 6—Referral number, explanation attached, which will substantiate your request for a decided increase in your next budget.

Now, you must be sure to attach a remark sheet showing your needs, otherwise your budget may be returned with only the former budget amount allowed.

No. 7—Would be empty until your budget is returned from management either approved, modified or discounted entirely.

WHAT CODES MEAN

I should like to call your attention to the coding of this budget. The legend and meaning of these letters or numbers must be defined in order to know what expense goes where. Here are a few examples:

HE1 P = Hospital Expense Private Areas (supplies & equipment).

UNE 2 = Uniforms Expense (for the division).

NRE 3B = Nurses' Residence Expense (for bedding *only*).

(Laundry budget would show 3A)

Special Services = dry cleaning, rug cleaning, window washing and so on.

The numbers shown next to HE1 P are to show you the other manner of coding; "E-700" stands for expense. Where, you ask? The accounting department has issued the housekeeping department a block of numbers which, in this instance, is 700 to 800. Each expense division will be E 700, E 701, and on up.

Salary coding will read S-700 to 800 if needed. "S" stands for salary and the number will be the same coding as for expense; the letter keeps them separate on your budget.

NRE2, *i.e.* repair of furnishings and equipment under the Nurses' Residence heading is a good example.

No. 1—Amount spent previous year.

(*Continued on Page* 136)

How can you *perk up their appetites?*

Patients are *people* and the way to the stomach is often as not through the eye, the mood, the spirit!

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(*Continued From Page 134*)

No. 2—Amount spent at the three-quarter mark of the year. You are still under your 1956 requested budget but you have to slow down or—

No. 3—the way you're going, estimated on a percentage basis, this is what you will have spent by December as—

No. 4—against your accepted budget request for the year 1956.

No. 5—Amount desired to meet your needs during the next year, 1957.

No. 6—When management sees such an increase the first question that enters its mind is Why? The No. 1 in the referral column refers to an explanation so that the hidden increase is explained not just taken for granted.

No. 7—This is the decision of management. In this instance $5000 was not approved, but $2000 was granted.

On a separate sheet you have listed explanations covering the referral numbers on supplies and expense and they should look like this:

No. 1—NRE2—Furniture repaired and or replaced. Draperies replaced.

No. 2—UPE1—Welting, binding and so on for slipcovers and upholstery work.

No. 3—UPE5—Yearly supply of materials for upholstering chairs in patient areas.

NOTE: Slipcover work is charged, at cost, to the division of the hospital for which it is made. Each month there is a credit due the upholstery department to defray the cost of material and labor. There should be no cost of operation shown during the year. However, you will have a small inventory of materials which will be considered operating expense for it will be used up during the following year and, of course, you must replenish each year to meet the planned requirements for decorating during the coming year.

The remaining items shown on the budget with increases requested for the coming year have codings which represent, generally, new equipment such as furnishings, floor covering, bedding for both patient areas and general, other than patient areas, and these needs will be listed on an additional sheet for budgeting new equipment requests (Fig. 2, page 132).

This sheet carries the same reference number given in the budget before the amount requested for next year. This new equipment budget sheet is not lined and therefore permits you to spell out fairly adequately the cost breakdown of the sum requested, showing why, where and when.

Last but not least is the budget for salaries and wages. I saved this until last because it is the simplest. It occurs to me that some of you might not have need for this extensive type of budget sheet for salaries and wages or, owing to your lack of understanding, this outline might cause panic. However, it really does not amount to much when it is explained. You will observe that approximately 85 per cent of the total budget goes to employes and 15 per cent goes to supplies (Fig. 3, page 132).

No. 1—Scale No.: Where the individual stands on his way up the ladder of advancement.

No. 2—Position No.: S-700, S-702, and so on.

No. 3—Vacation Code: If you are permitted to bring in personnel to cover as vacation relief for a limited period during the summer.

No. 4—Employe's Name.

No. 5—Exact Budget Title: assistant supervisor, supervisor seamstress, housekeeping houseman, housekeeping aide, or maid, floor mechanic, skilled houseman.

No. 6—Date Employed: Date employe came to work.

No. 7—Date Assumed Present Position: In case the person has changed his position and at which he has remained until this budget is prepared.

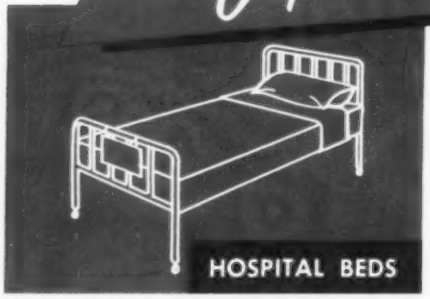
Nos. 8-9-10—Current Rate: What employe is now receiving. Approved 1956: what was approved last year. Requested 1957: what you wish for the employe this year.

No. 11—Key to Notes: This is the same as your reference numbers—explains the reason for your wish to increase or decrease the present status of the individual.

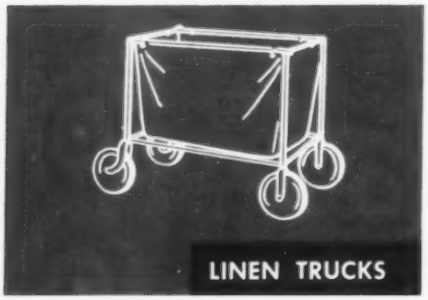
Nos. 12 & 13—Approved Budget 1957: This is the area where management enters its decision as to the amount and the effective date.

That finishes your tour of the budget department. This is an age of decisions and these budgets certainly require decisions on your part, decisions which you can't avoid or run away from, for today the current of progress leaves no place for indecisiveness. You are the gatekeeper for new ideas; therefore during the year you should gather into your mind all new, constructive ideas and put them to work in preparedness for the budget.

Silent! Dependable! **KILIAN Ball-Bearing Casters**


HOSPITAL BEDS


SERVICE TRUCKS


LINEN TRUCKS


FOOD SERVICE


BEDSIDE TABLES

The only caster with proven performance for outstanding . . .

HOSPITAL SERVICE

Quality built for continuous performance, Kilian casters have a record of use that makes them the natural choice for hospital service. All metal parts are machined from bar stock and all ball bearing parts fully heat treated to give the long life and trouble-free service vital for hospital use.

Experiences of hospitals equipped with Kilian casters give adequate proof of the smooth-rolling, lasting dependability that can be expected.

—Fine new institutions like the Hospital for Sick Children in Toronto, for example. When the hospital was opened, every bed, cot, and mobile equipment were fitted with Kilian casters—backed by a five-year guarantee. Typical of the durability built into each Kilian caster, NOT ONE FAILURE WAS REPORTED IN FIVE YEARS OF CONSTANT USE.

You can profit from the experiences of institutions like the Hospital for Sick Children—by selecting the caster that has won its reputation through proven performance

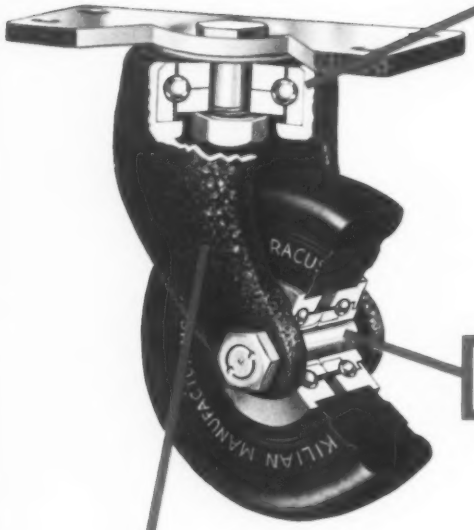
KILIAN *Casters*

THE ONLY CASTER GUARANTEED TO GIVE A MINIMUM OF FIVE YEARS OF DEPENDABLE, TROUBLE-FREE SERVICE

WHY? SEE OTHER SIDE . . . . . →

KILIAN *Ball Bearing* CASTERS

Guaranteed Performance is Built Into Every Kilian Caster



SILENT POSITIVE SWIVELING

to provide safe, easy movement —

Ideally suited for hospital service, Kilian casters are uniformly processed to include features that result in positive swiveling, and easy, quiet rolling action. A self-contained swivel bearing in the forks eliminates the possibility of loosening of the bearing and loss of steel balls. In the wheels, ball bearings instead of plain metal bushings reduce friction and contribute to better and sure, easy movement.

STRONG, DURABLE STRUCTURE

to eliminate time-consuming maintenance problems . . .

All metal parts (wheel bearings, swivel assemblies, axles and nuts) are machined from bar stock, with bearing surfaces fully heat treated for longer life. Only Grade A steel balls are used, held to a tolerance of .0005". The two wheel bearings are of the labyrinth sealed type and are fully grease packed for life to lock out all dirt. Swivel forks, stationary forks, as well as brake parts are malleable iron which will take many times the abuse of steel stampings.

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— to meet exacting hospital standards —

In appearance, too, Kilian casters show the superior manufacturing that has made them the choice of hospitals. All exposed parts are cadmium plated for better appearance and to counter corrosion. Choice of finish in either black or silver ripple.

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new Self-reseating safeties for patient protection

new Exclusive *REGULITE* adjusting cap for error-free flow setting

new Engineered for vertical positioning of humidifier

new Stabilized seats prevent freezing, vibration and seat ignition

Diaphragms are of special stainless steel. Nylon pointed adjusting screw prevents metallic friction. Easy-reading 2" gauges are color-coded with white calibrations (4000 lb. H.P. O_2 gauges for extra safety).

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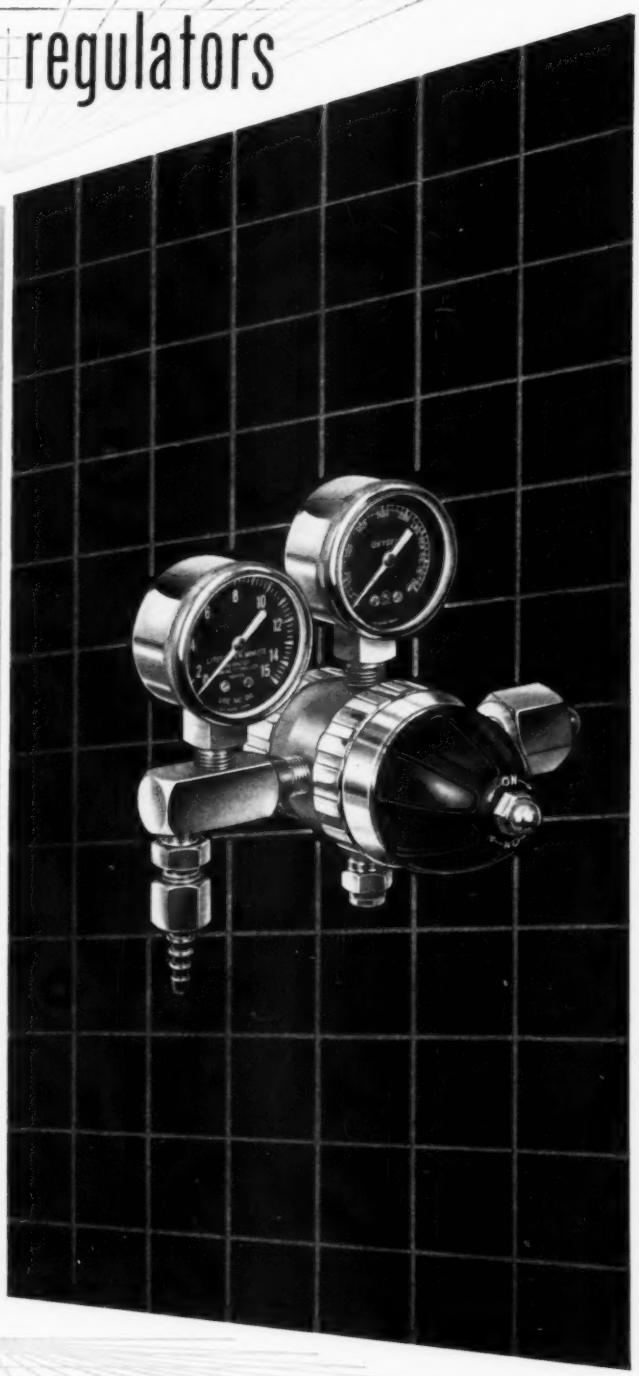
Liquid also produces famous RED DIAMOND Medical Gases.



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Coded List Prevents Laundry Losses

When a survey showed that laundry shortages resulted from lack of proper identification of various pieces, the problem was solved by devising a code everyone could understand without worrying about names

MURRAY E. HILL

SINCE the opening of this hospital, our laundry has been handled on a contract basis by a large firm in a near-by city at a rate of only 6 cents per pound on a pickup and delivery basis each day. This contract seems too good to be true, but, on the other hand, it once gave us considerable trouble owing to the frequent shortages.

Our system had always been that the laundry from various departments was gathered together in a specified place, there sorted and handled by the housekeeping department, using a laundry list supplied by the company that does the laundry. In spite of the fact that our housekeeping department checked and listed each item carefully, there was always a shortage. Exhaustive investigation by both the hospital and laundry usually brought to light a different interpretation by the hospital and laundry as to the identification of a certain item, which proved that no shortage existed.

Several years ago we conceived the idea of identifying each piece of linen used in our hospital with a code number. A list was prepared for the use of the laundry firm and the housekeeping department. This list was prepared in alphabetical order and with the code number opposite each item of linen. Each piece of linen, regardless of its use, was stamped with the hospital's identifying signature. Then in two opposite corners, or in other easily accessible places, the code number and the date put in use were placed on the item.

As an example, a reference to the accompanying list will show how simply the code was established. Aprons, cook, became A-1; aprons, maids, became A-2; wrapper, small 15 by 15, became W-2, and so on. We simply started each letter of the alphabet with the figure 1, permitting us to have as many items as needed under each letter and also enabling us to add to the list and the code without disrupting the entire group.

Thus, it became an easy matter for those checking the laundry to count the number of items with the corresponding code number and to place

Mr. Hill is administrator of Tunica Hospital, Tunica, Miss.

LAUNDRY LIST

TUNICA COUNTY HOSPITAL

Checked Out By ____ No ____

Checked In By ____ Date Out ____

Date Returned ____

MAKE IN DUPLICATE — RETAIN DUPLICATE — FILE NUMERICALLY

ITEMS		OUT	OVER	SHORT	ITEMS		OUT	OVER	SHORT
APRONS, Cook	A-1				RAGS	R-1			
Maids	A-2				SHEETS, Bed	S-1			
BATH ROBES	B-1				O. R. Green	S-2			
BED PAN COVERS	B-2				O. R. White	S-3			
BED SPREADS	B-3				O. R. Drape Green	S-4			
BLANKETS, COTTON—Wash and Fluff Dry	B-4				O. R. Drape White	S-5			
Wool (Dry clean)	B-5				O. R. Small White	S-6			
BLOUSE, White	B-6				O. R. Tonsil	S-7			
Blue	B-7				SHIRTS, White	S-8			
CAPS, Surgery	C-1				Work	S-9			
CRIB PADS	C-2				Scrub	S-10			
CIRCUMCISION SHEETS	C-3				SMOCKS	S-11			
CURTAINS, Patient's Room	C-4				TOWELS, Bath, Large	T-1			
DRESSER SCARFS	D-1				Bath, Small	T-2			
GLOVES, Pockets	G-1				Dish	T-3			
GOWNS, Opr. Green	G-2				Face	T-4			
Opr. White	G-3				Surgery Green	T-5			
Patients, Adult	G-4				Surgery Printed	T-6			
Patients, Child	G-5				O. B. Printed	T-7			
Patients, Exm.	G-6				UNIFORMS, Jumper Blue Striped	U-1			
HOT WATER BOTTLE COVERS	H-1				Jumper White	U-2			
LAUNDRY BAGS	L-1				Maids Blue	U-3			
LEGGINS, O. B.	L-2				Scrub	U-4			
OXYGEN TANK COVERS	O-1				White	U-5			
MATTRESS PADS	M-1				WASH CLOTHS	W-1			
MAYO STAND COVERS	M-2				WRAPPERS, Small 15 x 15	W-2			
PANTS, White	P-1				Medium 18 x 20	W-3			
Work	P-2				Large 30 x 38	W-4			
Scrub	P-3				Ex. Large 52 sq.	W-5			
PILLOW SLIPS	P-4				Head	W-6			

LIST UNIFORMS BY INDIVIDUALS ON REVERSE SIDE

The coded laundry list used at Tunica County Hospital obviates the usual scramble to identify items with which laundry workers may be unfamiliar.

that number in the check-out column on the laundry list. It is not necessary for the checker to know the name of the item.

This list was prepared in duplicate and one copy was placed with the outgoing laundry. So that the list would not be lost, a pocket was stitched on the bag, well marked with indelible ink so that it would be noticeable in the laundry receiving room. The use of this list made it easy for the firm's employes to check our laundry at the plant merely by using the code number. Items with which they were otherwise unfamiliar were readily identified.

Also, our housekeeping department experiences no difficulty in checking our laundry back in. If the list shows that 10 G-2's were sent out, then 10 G-2's should be returned. It matters not to the laundry or to the housekeeping department whether this is called a patient gown or surgical gown or some other type of gown.

LAUNDRY WELCOMES LIST

The use of this laundry list has been heartily welcomed by our laundry firm, which, incidentally, was on the verge of asking for a price increase at the time we developed this code list, because of the existing confusion which often placed it in the position of being short on certain items.

Now, we are happy to say, with the use of this list we rarely have any differences with the laundry firm. Further, it is seldom that we have any difficulty in sorting, stacking and checking our linen inventory, for we carry all our inventory cards, purchase records, and storage space marked with the same code we have on our laundry list. This list, of course, is expandable, and the one we now have in use has been enlarged as time has passed.

Since the use of a code list in our laundry proved so successful, we have instituted a similar code list to give us better control in other departments. We recently have prepared a code list of all printed items, whether printed locally or purchased as ready printed matter. We carry our sutures, syringes, I.V. solutions, and many other items on a code list similar to the laundry lists. These lists have not only speeded up our inventory but also have saved considerable money by preventing overpurchasing.

And so in our hospital, when the question is asked "This thing—what is it?," we know the answer.

New QUIET for Hospital Quiet-Zone

When quiet prevails in a hospital, everyone benefits. In many of the country's hospitals, such as the Indianapolis Community Hospital, sound-absorbing ceilings of Acousti-Celotex Tile bring *quiet comfort* to all areas . . . speeding patient convalescence, raising personnel efficiency and morale. Acousti-Celotex Sound Conditioning checks noise effectively in corridors, lobbies, kitchens, utility rooms, wards, nurseries, operating and delivery rooms. **Mail Coupon Today** for a *free analysis* of the noise problem in your hospital, plus free booklet.

Delivery room of the Indianapolis Community Hospital, Indianapolis, Indiana, showing ceiling of Acousti-Celotex Random* Pattern Perforated Mineral Fiber Sound Conditioning Tile. **Architect:** Daggett, Naegele & Daggett. **Acousti-Celotex Contractor:** Hugh J. Baker & Co.

*PAT. NO. D-168,763

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Name _____ Title _____

Hospital _____

Address _____

City _____ Zone _____ State _____

This Hospital Has Everything Except Money

(*Continued From Pape 79*)

the hospital on schedule, the city council, after several projected opening dates had passed, fired the entire staff in the middle of July. Mrs. Horan promptly volunteered and was accepted to work without pay for a month or more. The other employes waived two weeks' dismissal pay in the interest of the hospital fund.

The council took this drastic action, Mayor Zagortz explains, because it had no money and no immediate prospects of getting any to open the hospital. The city attorney warned the councilmen against voting any use of tax money, even extremely temporary use, for the hospital on pain of being sued by irate citizens for individual and personal repayment of the monies so used. The councilmen are understandably careful in the face of a report circulating through the town that a group of citizens who do not care for the council members have paid an attorney $2000 to watch and wait for possible grounds for suit against the councilmen.

The city attorney also ruled that there would need to be a minimum of $60,000, figured at the rate of $20,000 per month for three months, in operating capital in the hospital fund before the council dared swing open the doors. This, coupled with the ban on use of tax money and a further ban on borrowing from a bank or other source—there seem to be a number of citizens willing to advance operating funds—quickly added up to a ban on opening the hospital at all.

The state bureau of hospitals, which allocates the Hill-Burton money in California, suggested that the city lease the new plant to some outside interest. After the *Los Angeles Times* ran a story about Barstow's woes and the suggestion of the bureau, would-be lessees kept interrupting Mayor Zagortz' meals and even his slumbers. But the mayor and the councilmen felt somehow that all the federal and state money in the hospital precluded their taking any action on a lease.

So there is the mayor and there is the council and there is the hospital with lonely Mrs. Horan checking off supplies one moment and running out to the air conditioning machinery the next. But there is hope that the hospital may be opened before the end of the year—perhaps in time to serve as a Christmas present for the Barstowians and their neighbors.

WANT TO BE GOVERNING BOARD

A group of citizens recently completed work on petitions calling for a special election at which the electorate will be asked to give the city council all the powers the council's attorney says it doesn't have now—power to *be* the governing board of the hospital, as well as power to make use of tax money, if necessary to the successful operation of the hospital.

Meanwhile money trickles into the hospital fund from all parts of the country. After *Life* magazine published two pictures of the hospital and gave a brief résumé of its troubles last month, the contributions from outlying parts of the country, like Massachusetts and South Carolina and Chicago, were moving into the hospital fund in greater volume than the money contributed in and around Barstow.

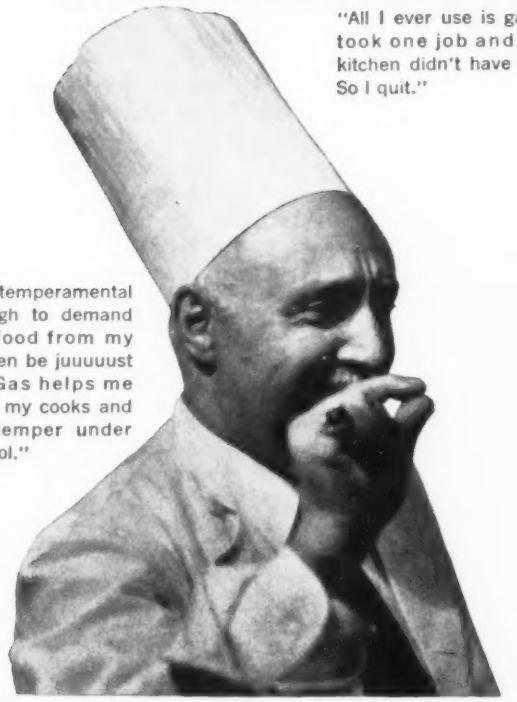

"GAS?

I WOULDN'T COOK WITH ANYTHING ELSE!"

Nedjar Elie, Chef, Dallas Athletic Club

"All I ever use is gas. I took one job and the kitchen didn't have gas. So I quit."

"When a member says, 'Give me a three-minute-egg in a hurry,' what can you do? You've got to have gas."



"I'm temperamental enough to demand the food from my kitchen be juuuuust so! Gas helps me keep my cooks and my temper under control."

Chef Elie serves about 800 meals a day in the downtown Dallas Athletic Club. The number varies slightly, but he knows that with his trained staff and flexible, speedy gas equipment every order gets individual attention. Chef Elie has worked in some of the nation's finest clubs and hotels . . . and they've all cooked with gas.

"Without gas, you can't get fine results along with fast service. We're so satisfied with our present gas equipment that the kitchen of our new country club in suburban Dallas is being built around the latest gas equipment."

If you plan to install a new kitchen or remodel or expand your present one, be sure to check with your Gas Company's Commercial Specialist. He'll be glad to discuss the economies and results modern Gas equipment provides. *American Gas Association.*

See Playhouse 90 with Julia Meade on CBS-TV. Watch local listings for time and station. Sponsored by your Gas Company and the Gas Industry.

NEWS DIGEST

University Report Shows Pharmacy Needs of Small Hospitals . . . Maine Institute Emphasizes Team Approach to Hospital Care . . . Michigan Legal Counsel Issues Opinion on Retaining Medical Records . . . Many See Film on Fire Safety Technics

Small Hospitals Need Pharmacy Services, University of Michigan Survey Indicates

ANN ARBOR, MICH. — Only 30 of the 102 small Michigan hospitals surveyed recently utilize the services of a professional pharmacist on a full-time or part-time basis, according to researchers from the University of Michigan College of Pharmacy who conducted a study of pharmaceutical services in Michigan hospitals of fewer than 100 beds.

The remaining small hospitals, which make up 70 per cent of those surveyed, have their prescriptions compounded at local drugstores.

The researchers, directed by Dr. Alex Berman, stated that "small hospitals need more than just prescription compounding from the professional pharmacist."

Hospitals need the comprehensive services of a pharmacist, the report said, adding that the pharmacist should work closely with the administrator, nursing staff, and medical staff. "He should be able to introduce and supervise a significant program of drug control and standardization," the researchers explained.

The report said that "although compounding would be an important element of this program, it should also include other elements such as purchasing, dispensing, labeling, hospital formulary, records, pharmacy and therapeutics committee, costs, pricing of drugs to patients, manufacture, and policy."

Half of the administrators in the 72 hospitals with neither part-time nor full-time pharmacists stated that financial problems made it impossible for them to employ a pharmacist.

Of the 30 hospitals with pharmacists, many administrators said that "employing a pharmacist had greatly improved the financial status and efficiency of their pharmacy operation." They were enthusiastically convinced that all small hospitals should follow suit in obtaining the assistance of a professional pharmacist, the report continued.

Annual purchases of drugs by small hospitals in Michigan are a significant factor in the over-all expenditures of the institutions, the report stated, noting that the total annual purchase of drugs, excluding anesthetic gases, in 96 hospitals was $1,447,889.

From this, the report added, it would seem that the smaller hospitals have a considerable financial and legal stake in maintaining efficient controls, which a professional pharmacist is capable of providing.

Most of the administrators interviewed expressed strong interest in the development of a program such as extension work institutes, workshops, or other forms of field work dealing with pharmacy services in small hospitals, the researchers said.

The project will continue during the coming year, according to Dr. Berman, under a new grant for human resources research from the Michigan state legislature. Dr. Berman stated:

"We expect to do case studies, to be carried out by a specialist from our college of pharmacy, who will seek, under 'workshop' conditions, the extent to which a community pharmacist can provide a substantial service to the hospitals. From this study, it is expected that the professional services of the community pharmacist will be available to the small hospitals."

Baylor Employes Dig Deep

DALLAS, TEX.—Employes and private duty nurses of Baylor University Hospital, a 600 bed institution, have donated $35,702 to the hospital's campaign for a new women and children's building, the employe newspaper announced. An over-all goal of $2,500,000 is sought.

Fire Safety Training Film Viewed by 25,000 Persons, Lt. McGrath Estimates

CHICAGO. — Approximately 25,000 viewers in hospital and nursing audiences have seen the moving picture, "Emergency Removal of Patients and First Aid Fire Fighting in Hospitals," Lt. Robert McGrath of the Chicago Fire Department, whose fire safety technics are demonstrated in the film, estimated last month.

The picture shows Lt. McGrath working with nurses at Presbyterian-St. Luke's Hospital, Chicago, and it has been shown at hospital and nursing meetings in all parts of the country.

In addition to demonstrations conducted by Lt. McGrath himself at a number of state hospital association meetings, the film has been shown more than 700 times to audiences varying in size from 10 to as many as 300 persons, it was reported.

The film is being distributed by Abbott Laboratories, North Chicago.

Maine Hospital Institute Stresses Team Approach

WATERVILLE, MAINE.—"The Team Approach to Complete Patient Care" was the theme of the 13th annual Institute for Hospital Administrators in Maine, held at Colby College here, September 4 to 6, in cooperation with the Maine Hospital Association. Approximately 30 hospital people from all sections of the state attended to consider not only the need of developing an effective team comprising administration, medical staff representation, and major department heads, but how to effect such a team and the rôle played by each member. The voice of the patient, too, was heard in expressing the importance of greater emphasis upon his mental, emotional and spiritual needs.

Practicing spiritual therapy as viewed by the administrator, the clergy, the

(*Continued on Page* 168)

This Man Knows how to help prevent O. R. explosions

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The Man Behind the Drum

Nearly a half century of experience in dealing with specialized hospital problems is at your service without cost when you contact the man behind the drum . . . your Huntington Representative.

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Michigan Legal Counsel Presents Opinion on Preservation of Records

LANSING, MICH.—Protection of the doctors, hospitals and patients would seem to be the prime consideration in keeping records, according to legal counsel of the Michigan Hospital Association.

The opinion was in answer to a question referred to the committee on patient care of the council on professional services as to the length of time a hospital should preserve a medical record.

The counsel also stated that it could well be that some legislation should be enacted commanding the maintenance of medical and hospital records for a given period of time.

"The hospital should be increasingly interested in maintaining such records in view of the definite tendency of the courts toward legal responsibility of hospitals for negligent care of patients," the opinion said, noting that several malpractice suits in the state had been started in which the hospital was joint with the doctor as the defendant.

The next question, said the report, is how long should the records be kept? "The answer would seem to depend upon what type of case is involved, and whether the patient were an adult or a minor," said the opinion. "If a personal injury action, other than malpractice, is involved, the patient has three years from the date of the accident in which to start suit. If the patient is a minor, however, he may wait until he attains his majority before he starts suit. On the other hand, he may sue by having a guardian or next friend appointed, probably the most usual procedure."

In malpractice cases, the patient may institute suit within a period of two years from the last time he was seen professionally by his doctor. "While the question has not yet been answered in this state," the counsel said, "we assume that if the hospital were joined in such action, suit would have to be started within two years from the last day of hospitalization.

"In workmen's compensation cases, there are several different rules as to limitation of starting action, depending entirely upon the circumstances. We think the two-year period of limitation is the one of primary importance to you, although proceedings for further compensation, after payment has been made for a period, may be brought at any time within 500 weeks from the date of accident."

The opinion stated that legislation might be indicated, primarily for the protection of the hospital which has destroyed records that a patient may subsequently need in connection with litigation.

This raises the question as to whether a hospital could be held negligent in failing to anticipate the need of maintaining records for patients who might become litigants, the report pointed out. "It might be that such possible liability might be waived by a patient if the application for admission recited that hospital records would be kept only for a given period of time, unless within such time the patient made written request to have them kept longer," the report said.

"We understand the general rule to be that x-rays and hospital records are property of the hospital. With the general tendency of courts to increase rules of liability no one can say that the supreme court of this state would lay down the same rule if the problem were presented today," the opinion concluded.

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NEW YORK • 10

Health Foundation Issues Preliminary Report on Improvements in Hospitals

NEW YORK.—Recent improvements by general hospitals in such human factors as number of patients served, number of lives extended, and amount of pain and disability reduced are pointed out in the statistical bulletin *Progress in Health Services* published August 30 by the Health Information Foundation, New York.

These improvements were revealed in a study, sponsored by the foundation, of the records of all patients admitted to Beth Israel Hospital, Boston, for the years 1932 and 1952, conducted under the direction of Dr. Cecil G. Sheps, executive director of the hospital. The years chosen, according to the bulletin, were considered "representative of distinct eras in medicine and hospital care, *i.e.* before and after the current era of sulfa drugs, antibiotics and other great advances in therapy."

In this preliminary report of the study, it was stated that during the 20 year period the annual number of patients admitted to Beth Israel rose from 3767 to 7820. Although the increase was due in part to the addition of 30 beds over the 194 available in 1932, of even more importance was a more extensive use of existing beds —from 70 per cent occupancy in 1932 to 93 per cent in 1952—and a reduction in the average length of stay from 12.8 to 9.8 days. The result was an increase in the annual number of patients per bed of from 19.4 to 34.9, it was reported.

Other findings revealed in the report included: a decline in the annual death rate from 52 per thousand patients to 34 per thousand, even though the average age of patients advanced from 35 to 47 years; an increasing proportion of middle-aged and elderly patients, and a decline in the ratio of surgical to medical cases. It was noted also that although admissions among the middle-aged and elderly had risen, more young children were also admitted in 1952. The result is a "clustering of care for the patient during the early and late years of life," the report stated.

The study also showed that hospitalization for certain diseases, such as mastoiditis, has diminished and that it has been shortened considerably for others, such as infections of the urogenital tract. Admissions for arteriosclerotic heart disease, however, have greatly increased.

The trends shown by the report point to a need for continual study and evaluation of the job ahead for hospitals, according to Health Information Foundation officials. "For the public, they imply a broader understanding that hospital care is worth more and costs more; that by budgeting further through voluntary health insurance, increasingly valuable hospital care will be available to all as it is needed."

Hospital Awards Contracts for $3.6 Million Addition

FORT WORTH, TEX. — Contracts have been awarded for a $3,600,000 addition to St. Joseph's Hospital here. The new five-story structure will be designed for eventual expansion to 12 floors and will be erected in front of the present hospital building. It will include a radiology department, two emergency rooms, an outpatient department, a maternity floor, and a mental health ward. Another 125 general medical beds will be included in the new building.

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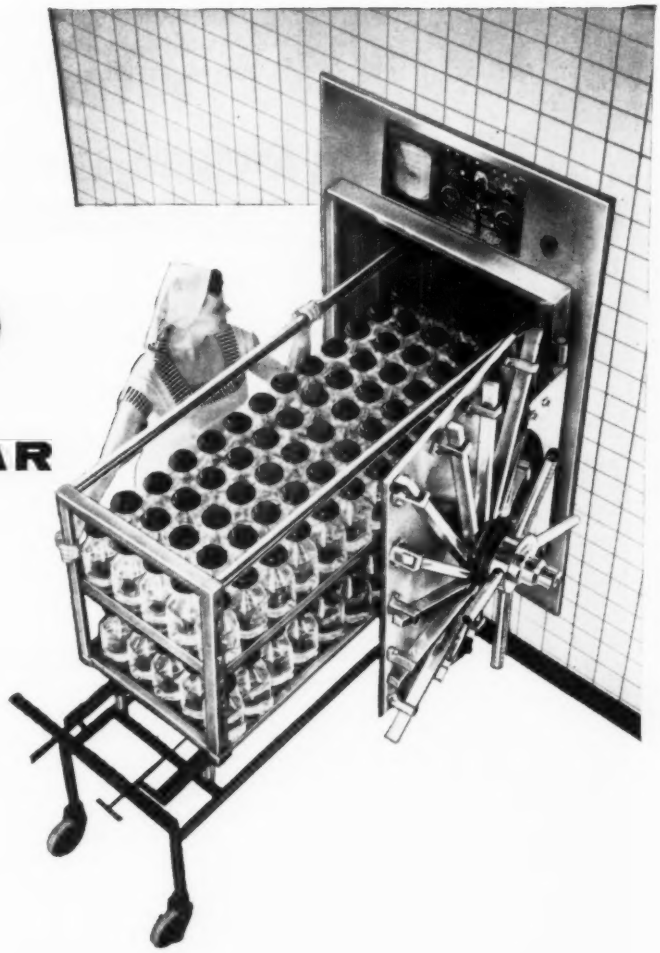

Features:

- M. E. construction . . . Monel End Ring welded to nickel clad interior for complete armor against rust or corrosion.
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- Vacuum drying keeps work area cooler and drier.
- Solution exhaust valve speeds cooling of flasked fluids.
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American Model M. E. Sterilizers meet the modern need for large capacity steam sterilization of everything from surgical and obstetrical packs to treatment trays or flasked solutions. They have many specific features which make them easier, faster and more comfortable to use and less costly to maintain.

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National Survey Reveals Acute Personnel Shortage in Most Health Fields

NEW YORK.—Shortages of qualified health personnel are so acute that in some health fields the need for more personnel is greater than the total already in the field, a National Health Council survey has revealed.

The survey indicated that shortages exist in virtually every health profession, and that these shortages are probably most severe in the South and least critical in the Northeast.

Reports from a number of associations representing various health professions indicated needs as follows:

Occupational therapists. There are currently 5200 registered occupational therapists in the U.S., with another 8000 needed by the end of the year. About 16 are needed for each graduate into the profession disregarding the annual drop-out rate.

Physical therapists. The need is for 13,600 physical therapists as compared with an active supply of only 7800. Today there is less than one physical therapist per 22,000 population.

Medical and psychiatric social workers. The National Association of Social Workers reported that about 3500 medical social workers are needed right now, with about three times as many jobs available as there are qualified applicants.

Medical technologists. There are openings for 73,000 registered medical technologists, according to the National Committee for Careers in Medical Technology. At present there are 23,000 in the field.

Dietitians. The American Dietetic Association said, "The supply of qualified dietitians and nutritionists will not meet the demand for at least another decade. Approximately 2000 persons are needed to fill accumulated vacancies and new openings."

Orthoptic technicians. At present there are 208 certified orthoptic technicians, and the American Orthoptic Council reported that this number could be doubled.

Medical record librarians. More registered medical record librarians are needed in all hospitals, but particularly in those with fewer than 100 beds, according to the American Association of Medical Record Librarians.

X-ray technicians. Another 15,000 x-ray technologists will be needed in the next five-year period. There is a national shortage, particularly in communities with small hospitals.

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● **Comfort and morale** of the resident staffs are enhanced by appropriate colors in their living quarters. Pleasing colors in reception and waiting rooms give visitors confidence and encouragement.

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How to get a planned color Study—FREE

● To help you color-plan correctly next time you paint, we'll be glad to send you a completely new booklet explaining what COLOR DYNAMICS is and how to use it in your hospital. Better still, we'll make a detailed planned color study for your hospital with complete specifications, without cost or obligation. Call your nearest Pittsburgh Plate Glass Company branch and arrange to have one of our representatives see you at your convenience. Or send this coupon.

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Public Health Group Seeks to Aid Communities With New Consulting Service

NEW YORK.—A consulting service to help communities cope with problems in mental health, chronic disease and rehabilitation, medical care administration, and public health administration has been announced by the American Public Health Association.

Accident prevention, child health, environmental health, and radiological health also will be included.

A committee of experts in each area will develop policy statements; write operating manuals; conduct field studies, surveys and demonstrations, and consult with state and local health authorities and agencies, the association said.

Among current priority health needs noted by a report urging formation of the service are:

1. To increase the competence of individuals, families and communities to cope with their own health problems.

2. To develop a safe environment in the home, on the road, at work and at play.

3. To extend the principles of the hygiene of housing to include adequate recreational space and special provision for such groups as children and older people.

The report also advised increased emphasis on air pollution abatement, stream sanitation and radiation control; study of health implications in technological developments, and an attack on unsolved health problems.

Canadian Pharmacists Announce New Plan for Prepaid Drug Insurance

WINDSOR, ONT.—A program of prepaid drug prescription insurance has been announced by a group of Windsor pharmacists. The new plan, patterned after hospital and medical insurance plans, is believed to be the first of its kind in North America, it is reported.

Prescriptions of Windsor and Essex County subscribers will be filled at an expected average annual cost of $10 per person. The program, to begin Jan. 1, 1958, for a three-month trial period, will be limited initially to 1000 subscribers.

The sponsoring pharmacists have formed a nonprofit corporation called Prescription Services, Inc., to administer the program. All 60 Windsor pharmacists have agreed to take part in the plan during the trial period.

The drugstores will be paid by the corporation at rates based on the pricing list of the Canadian pharmaceutical code.

Both group subscriptions and individual subscriptions are available. Under the group plan, each subscriber will pay 95 cents per month, another 95 cents for his wife, 65 cents for the first child, 55 cents for the second child, and 45 cents for the third child.

Lenox Hill to Construct 12 Story Hall of Nursing

NEW YORK.—A $2,750,000 building project to help in recruitment of nurses has been announced by Lenox Hill Hospital. The program involves construction of a 12 story hall of nursing, plus renovation of the present nurses' residence, built in 1917.

The project will permit a 50 per cent expansion of the student body, according to Theodore F. Childs, hospital president.

Maybe you helped write this

Happy Ending...

A child patient is quite a problem. Give him half a chance and he'll wrap you around his little finger! You're proud you've helped him . . . but you feel a little heart-tug to see how glad he is to be going home.

1. *Nurses, doctors, administrators, beware!* Pediatric patients have a way of sneaking into your heart. Of course they do everything in the book to claim attention, to avoid "shots" and medication. They stray. They give the wrong name. They sometimes cry. But despite the deviltry, they're brave little angels, every one. And when it's time to send them home . . .

2. *You* need a stout heart to withstand the *pride* that wells up in it when the little patient's mother comes to dress him up to go. (You'd need a heart of steel had the story ended differently.) So you're doubly glad you gave the little boy everything a hospital can give to assure recovery. You're especially glad you provided the one perfect protection against misidentification...

3. *You're* thankful you gave your "pede" the added protection of Ident-A-Band® — the soft, plastic identification band he's wearing on his wrist. You're glad because it protects the little boy against misidentification . . . protects him from possibly harmful medicines or treatments intended for another . . . and glad because it saves time of busy nurses and attendants.

4. *Hurry*, mama!" Yes, your little patient — almost mended — wants to go home. The little fellow has had his tests of courage. And (thanks to your good management) found things as homey as can be in a modern hospital. He'll wear his Ident-A-Band home and show it to his friends. They'll be as much taken as he was with the animal picture on the name card.

5. *Hurry*, daddy! Put me in our car!" You've had a part in many such Happy Endings. And, because making improvements, setting up new safeguards are important to you, your "Happy Ending" record will be better, year by year. You will undoubtedly want to provide Ident-A-Band protection against mixups, too, as soon as possible. "Pede" band costs less than 10¢.

6. *There* is, of course, only one completely practical way to give patients *positive* protection against mixups. That's Ident-A-Band. Each band tailored-to-measure to the patient's wrist — all data *sealed inside* the transparent band and *permanently* sealed around the wrist. Band can't be removed or the data changed without destroying the band. Write for data.

HOLLISTER FRANKLIN C. HOLLISTER CO., 833 N. Orleans St., Chicago 10, Ill.

Are you using the sealed-on patient identification that's so

Quick and easy to apply?

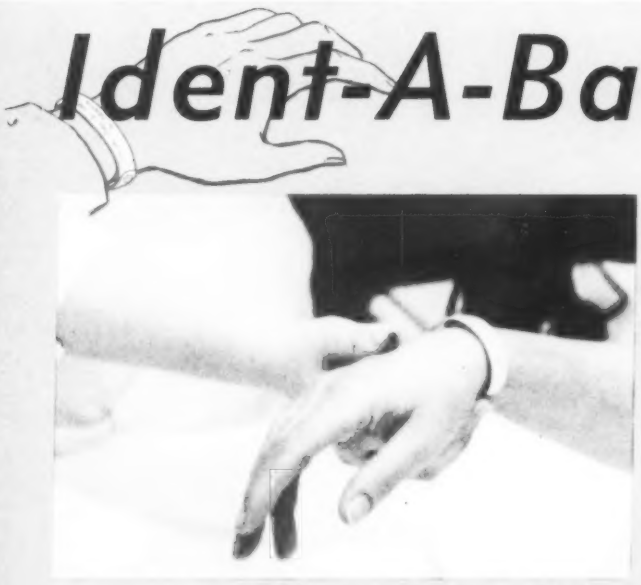
With Ident-A-Band, it's quick and it's easy to apply on-the-wrist identification that fits the individual wrist perfectly. Measure the wrist with the band itself. Punch hole for seal and tuck identity insert card *inside* the band where it's protected against alteration and moisture. Each "made-to-measure" Ident-A-Band goes on in seconds!

A smooth metal seal *permanently* locks the identifying data *inside* the Ident-A-Band. *That's* positive protection! Identifying data cannot be changed or the band removed without destroying the Ident-A-Band itself. The Hollister Sealing Instrument, especially designed to form this rivet-strong, permanent seal — *makes it easy* to apply.

A quick, rounding-off snip and the Ident-A-Band's ready to wear — for days or weeks or months. It's "made-to-measure" for comfort and safety, yet goes on in seconds. Only Ident-A-Band gives this permanently *sealed on* and *sealed in* protection . . . at a cost so reasonable that every hospital can easily afford it.

Ident-A-Band®

PREVENTS MIXUPS!



Patient's name, doctor's name, hospital number and other needed data are always in plain view on the patient's wrist. Ident-A-Band provides* positive *protection against mixups.

AND IT IS MOST ECONOMICAL

Only about a dime — a little more or a little less depending on annual usage — protects the patient against the hazards of misidentification. *Really protects* with the permanently sealed on-the-wrist identification proved on millions of patients. A letter or postcard will bring you complete information on Ident-A-Band. If you would like an identification survey and estimate for all-patient protection in your hospital, include approximate annual number of OB, pediatric and adult admissions.

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1 extra inch gives 20% more air in a Purkett Conditioning Tumbler and speeds up production

More drying in the same length of time with shorter tumbling cycle possible with the new 6-inch squirrel type fan.

Mark up another improvement in the 72" 12-ring Purkett Pre-Drying Conditioning Tumbler . . . . another example of keeping the Purkett far ahead in large flatwork and garment conditioning operations.

By increasing the size of the fan but one inch and using a larger 1½ hp. motor with a larger duct, production is speeded up. To the operator this means a shorter tumbling cycle with the same amount of drying possible, or more drying in the same tumbling time may be obtained.

This is but one of many features described in a new folder which will be sent gladly upon request.

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Without cost or obligation to you, ask for a Purkett engineer to help you solve your special problems. He is a specialist in linen and garment conditioning.

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Purkett equipment is sold by ALL Major Laundry Machinery Manufacturers and by

PURKETT MANUFACTURING COMPANY
Joplin, Missouri
DEPENDABLE PRE-DRYING CONDITIONING TUMBLERS

ABOUT PEOPLE

(*Continued From Page* 80)

Donna M. Donald has been appointed administrator of Albany Hospital, Albany, Calif., succeeding **Leon A. Jaris,** who resigned after eight years at Albany to become administrator of Motion Picture Hospital, Woodland Hills, Calif. Mrs. Donald is a graduate of the hospital administration course at the University of California, where she also served as a research and teaching associate.

Robert E. Lee has been named assistant administrator of North Broward General Hospital, Fort Lauderdale, Fla. Mr. Lee received his master's degree in hospital administration from the Medical College of Virginia, and served his residency at the college and at North Broward Hospital.

Neil M. Glass has been appointed administrator of Bethesda Hospital, Chicago. The hospital, formerly Chicago Fresh Air Hospital, is being remodeled.

Alfred Muller Jr. has been appointed assistant administrator of General Hospital of Everett, Wash. Mr. Muller formerly was administrative assistant at St. Francis Memorial Hospital, San Francisco. He is a graduate of the University of California's program in hospital administration.

Mother M. Macaria, administrator of St. Francis Hospital, Lynwood, Calif., has been elected provincial superior of the Sisters of St. Francis of the West Coast province. Her office of Mother Superior and administrator at the hospital will be divided so that **Mother M. Noella** becomes Mother Superior and **Sister M. Christine** assumes the duties of administrator.


Malcolm D. MacCoun

Malcolm D. MacCoun has been named assistant administrator at St. Mary's Hospital, Grand Rapids, Mich. Mr. MacCoun received his master's degree in hospital administration from Northwestern University and after completing his residency served as associate director of Hackley Hospital, Muskegon, Mich.

Herbert G. Willis has been named administrator of the Community Hospital of Schoharie County, Cobleskill, N.Y. He replaces **Dan Jansen,** who served as administrator from the time the hospital opened in August 1956. Mr. Willis has been administrator of the Alice Hyde Memorial Hospital, Malone, N.Y. Mr. Jansen will remain at Cobleskill as hospital pharmacist for an undetermined length of time, it is reported.


Jerome R. Sapolsky

Jerome R. Sapolsky has been appointed administrative assistant of Beth Israel Hospital, Boston. He formerly was an administrative resident at the hospital, and received his master's degree in hospital administration from Yale University.

Dr. G. M. Little has been appointed superintendent of Natchez Charity Hospital, Natchez, Miss., succeeding **Dr. E. L. McAmis,** who resigned to devote his time to private practice. Dr. Little was recently discharged from the armed forces.

Sister Ellen Patricia, former acting administrator and assistant administrator of St. Elizabeth Hospital, Elizabeth, N.J., has been named to succeed **Sister Cecilia Bernard** as administrator. Sister Ellen Patricia is a graduate of

St. Louis University's hospital administration course.

Morris R. Smith, superintendent of Marinette General Hospital, Marinette, Wis., has resigned after nearly 50 years of service to county hospitals. He became superintendent of Marinette General seven years ago, after serving as superintendent of Marinette County Hospital, Peshtigo, Wis., for 41 years.

Sister Maureen has been appointed administrator of Mercy Hospital, Bay City, Mich., succeeding **Sister Mary Maurita,** who is now administrator of St. Mary's Hospital, Grand Rapids, Mich. Sister Maureen served as administrator of Mercy Hospital, Cadillac, Mich., for two years and was succeeded by **Sister Mary Grace,** former administrator of Mercy Hospital, Manistee, Mich. **Sister Mary Ida** has become administrator of the Manistee hospital.

Sister Ann Loretta has been appointed administrator of St. Joseph's Hospital, Lewiston, Idaho, succeeding **Sister Mary Esther,** who has been named administrator of Our Lady of Lourdes Hospital, Pasco, Wash. The duties of superior at the Idaho hospital will be assumed by **Sister Mary Felix,** who previously was head of the admissions office at St. Mary's Hospital, Tucson, Ariz.

Daniel Powers

Daniel Powers has been appointed assistant director of Barnert Memorial Hospital, Paterson, N.J., succeeding **Lester Bornstein,** who has been named assistant director of Beth Israel Hospital, Newark, N.J. Mr. Powers previously was assistant director of Beth Israel Hospital, New York, for seven years, and administrative assistant for the Hospital for Joint Diseases, New York, and the New York City department of health.

Carden M. Astin has been appointed administrator of Lawrence County Hospital, Lawrenceburg, Tenn. He formerly was administrator of Chilton County Hospital, Clanton, Ala. He is a graduate of the University of Georgia's hospital administration course.

Donald Nesbit, former administrator of the Kaiser Foundation Hospital in Walnut Creek, Calif., has been appointed administrator of the Kaiser Foundation Hospital in Oakland, Calif. He succeeds **W. F. Day,** who has been named regional administrator of Kaiser Foundation Hospitals in Northern California. **William E. Smikahl** will take over the administrator's post at Walnut Creek.

Sister M. DeChantal, administrator of St. Mary of Nazareth Hospital, Chicago, has become administrator of Nazareth Hospital, Mineral Wells, Tex. She succeeds **Mother M. Blanche,** who is relinquishing the position to devote herself to the duties of the Mother Superior. Sister DeChantal is a graduate of Northwestern University's hospital administration program.

Armour H. Evans

Armour H. Evans is the newly elected administrator of Methodist Hospital of Kentucky, Pikeville, succeeding **Stephens A. Lott,** who has been named assistant director of Hurley Hospital, Flint, Mich. Mr. Evans was associated with Wesley Hospital, Wichita, Kan., for 10 years. Before entering the hospital field, he was pastor of several Methodist churches in Kansas. He is a graduate of the hospital administration course at Northwestern University. Mr. Evans is a member of the American College of Hospital Administrators.

(*Continued on Page* 158)

(*Continued From Page* 155)

H. F. Zimoski Jr. has been named administrator of Foster Memorial Hospital, Ventura, Calif., succeeding **Gertrude W. Fuller, R.N.** Mrs. Fuller is retiring after serving as administrator for 28 years. Mr. Zimoski, a graduate of the Columbia University hospital administration program, has been business manager of Kaiser Foundation Hospital, Fontana, Calif. He is a member of the American College of Hospital Administrators.

Frank L. Unzicker, who resigned recently as administrator of Memorial Hospital of DuPage County, Elmhurst, Ill., is now associated with Leyden Community Hospital Foundation, a community group planning a 200 bed hospital near Chicago.

W. D. Hamrick has been appointed administrator of Southwest Texas Methodist Hospital, now under construction at San Antonio, Tex.

Sister Mary Magdalene, administrator of Mercy Hospital, Janesville, Wis., for seven years, has been transferred as administrator of Misericordia Hospital, Chicago. She will be succeeded by **Sister Loretta Marie,** who has been hospital consultant for the Chicago province with which the Janesville hospital is affiliated.

Taylor O. Braswell, former administrator of Fairfield Memorial Hospital, Fairfield, Ill., for six years, has been named administrator of the new Memorial Hospital of Belleville, Ill. The hospital is scheduled to open early in 1958. Mr. Braswell is a graduate of Northwestern University's hospital administration program.

Albert B. Osborne, assistant director of the University of Virginia Hospital, Charlottesville, Va., has been named administrator of Centreville Township Hospital, near East St. Louis, Ill. The new 125 bed institution is scheduled to open in March 1958.

Department Heads

Dr. Robert E. Slayton

Dr. Robert E. Slayton has been appointed director of medical education at St. Luke's Hospital, Chicago, to strengthen and direct the educational program for St. Luke's intern and resident staff. A graduate of the University of Chicago and of its medical school, Dr. Slayton was a resident at St. Luke's for two years and a fellow in medicine at Joslin Clinic, Boston.

Barbara D. Mills, director of housekeeping services at St. Luke's Hospital, Chicago, has been named director of housekeeping services for Allegheny General Hospital, Pittsburgh, effective October 15. Mrs. Mills will be succeeded at St. Luke's by **Opal Manny,** who now holds the position of supervisor of procedures in the housekeeping department.

Edith J. Evans has been named superintendent of nurses for Valley Presbyterian Hospital, Van Nuys, Calif. The first unit of the hospital, now under construction, is approximately 85 per cent completed. Mrs. Evans formerly was evening and night nurse supervisor at the University of California Medical Center. She is a graduate of Henry Ford School of Nursing, Detroit.

Sister M. Florian has become director of nursing at Nazareth Hospital, Mineral Wells, Tex., succeeding **Sister M. Maristella, R.N.,** who has accepted an appointment at Holy Cross Hospital, Taos, N.M. Sister Florian has been the clinical instructor at St.

(*Continued on Page* 162)

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Delivers stronger, more flexible sterile sutures[1]

—eliminates weak spots and kinks from tight reel winding...requires less handling...can be easily opened as needed so suture does not dry out...needle points and cutting edges are better protected

Cuts surgical costs[1]

—fewer sutures damaged or opened unnecessarily...saves gloves and linens...stores in ½ the space...*now costs less than tubes!*

1. Alexander, Edythe L.: Mod. Hosp., May, 1957.

NEW! Spiral Wound Gut now available in SURGILAR pack!

Other outstanding *hospital-tested* suture packages

SURGILOPE®

Sterile Pack Pre-Cut Silk and Cotton...aluminum foil envelopes... no glass to break...⅓ less storage space...costs less than tubes

MEASUROLL®

Silk, Cotton and Stainless Steel ...tape-measure box...one snip cuts multiple strands to desired length...saves waste, saves time...economy size silk and cotton costs less than spools

(*Continued From Page* 158)

Mary of Nazareth School of Nursing, Chicago. At the time of her new appointment she was engaged in a graduate research project in Washington, D.C.

Joseph G. Bertolami has been appointed assistant controller of Jackson Memorial Hospital, Miami, Fla. He formerly was night administrator of the hospital, where he also served his administrative residency. Mr. Bertolami is a graduate of the Columbia University program in hospital administration, a nominee of the American College of Hospital Administrators, and a member of the South Florida Hospital Council.

David List has been named personnel manager of St. Francis Hospital, Evanston, Ill. He has worked in the fields of counseling, guidance and placement for the Department of the Army and for private agencies.

William F. Martin has been appointed chief pharmacist at Newton-Wellesley Hospital, Newton Lower Falls, Mass. Mr. Martin is a graduate of the Massachusetts College of Pharmacy and formerly was associated with New England Deaconess Hospital, Boston.

Louis Gdalman has been named director of pharmacies for Presbyterian-St. Luke's Hospital, Chicago. Mr. Gdalman has been associated with St. Luke's department of pharmacy since 1930. He also is a lecturer in the school of hospital administration at Northwestern University, and on the faculty of Hospital Pharmacy Institutes, American Hospital Association. A charter member of the Illinois and national chapters of the American Society of Hospital Pharmacists, Mr. Gdalman is a past president and secretary of the

Louis Gdalman

E. Virginia Pinney

Chicago branch of the society. It has also been announced that **E. Virginia Pinney** will become director of dietetics of Presbyterian-St. Luke's Hospital. A member of the American Dietetic Association, Miss Pinney has been director of the dietary department at St. Luke's Hospital for the last nine years. Before going to St. Luke's, she had charge of food services for the state custodian school in Spokane, Wash.

Alice Holton has been appointed to the newly created post of public relations director for St. Alexis Hospital, Cleveland. Mrs. Holton, a graduate of Ohio State University, has been in publicity and public relations work for the last 19 years, including positions in industry and community organizations. She also spent several years as a newspaper reporter in Ohio.

Alice Holton

Miscellaneous

Wendell H. Carlson

Wendell H. Carlson, administrator of Englewood Hospital, Chicago, has been named executive director of the Chicago Hospital Council, succeeding **James R. Gersonde,** who resigned because of illness. Mr. Carlson will relinquish his post as president of the council to become its executive director. He is a past president of the Illinois Hospital Association and a fellow of the American College of Hospital

MODERN, FIRE-RESISTIVE HOSPITAL CHOOSES GRINNELL SPRINKLERS

Rhode Island Hospital, Providence, R. I.
Architects: Shepley Bulfinch Richardson & Abbott
General Contractors: Gilbane Building Company

Vital work areas get this extra measure of safety

The new, 12-story Rhode Island Hospital in Providence is exemplary of the latest and best in hospital design. Its facilities include 452 beds, 14 operating rooms, an administrative center, service rooms, cafeteria, kitchen, and office areas.

Despite use of fire-resistive materials in construction, nothing was left to chance. For fire records are filled with cases of "fire-resistive buildings" destroyed by fire. So Grinnell Sprinklers were installed in potential fire areas throughout the building.

Grinnell Sprinklers stand ready, day and night, year after year, to stop fire when it starts. The cost of such protection, moreover, is small compared to losses from fire, and especially since a Grinnell Sprinkler System reduces insurance premiums.

The best time to consider fire protection is at the planning stage. However, a Grinnell System can be installed in existing buildings with a minimum of inconvenience, and without disrupting normal hospital routine. Write Grinnell Company, Inc., 255 West Exchange Street, Providence, R. I.

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PROTECTION AGAINST EVERY FIRE HAZARD

Manufacturing, Engineering and Installation of Automatic Sprinklers since 1878

Administrators. **Stanley P. Farwell,** chairman of the council's board of directors, will serve as acting director until Mr. Carlson can leave his position at Englewood Hospital.

Dr. Robert A. Moore, former vice chancellor of the health professions at the University of Pittsburgh, has been named to succeed **Dr. Howard W. Potter** as president of the Downstate Medical Center of the State University of New York and dean of the center's college of medicine. The center is in Brooklyn, N.Y. Dr. Moore has served on the faculties of Ohio State University, Western Reserve, Cornell and Washington University, where he was dean of the school of medicine for seven years. He is immediate past president of the Association of American Medical Colleges.


Guy H. Trimble

Guy H. Trimble, chief of the Equipment Planning Branch, Division of Hospital and Medical Facilities of the Public Health Service, Washington, D.C., has accepted a position as hospital administration adviser to the Ethiopian Government. Mr. Trimble left to assume his new duties on September 15.


Gerald J. Malloy

Gerald J. Malloy, assistant administrator of St. John's Hospital, St. Louis, has been named executive director of the Greater St. Louis Hospital Council. A graduate of Marquette University law school, Mr. Malloy received his master's degree in hospital administration from St. Louis University and served as administrative assistant of Touro Infirmary, New Orleans. **Irene F. McCabe,** public relations director of St. Louis Blue Cross, has served as part-time executive secretary of the council since 1941.

Bill Burton, administrator of Southwestern General Hospital, El Paso, Tex., and a trustee of the Texas Hospital Association, has been named vice president of the association, following the resignation of **Sister M. Annella.** Sister Annella, formerly administrator of St. Ann Hospital, Abilene, is leaving the state to complete her master's degree in hospital administration at St. Louis University. **Sister Mary Vincent,** administrator of St. Joseph's Hospital, Fort Worth, was elected to the board of trustees to fill Mr. Burton's unexpired term.

James Neely, assistant director of research for the American Hospital Association, has been named full-time executive secretary of the South Carolina Hospital Association.


Frederic E. Markowitz

Frederic E. Markowitz has been appointed director of public information and research of the Cleveland Hospital Council, it is announced by **Thomas D. Griffiths,** executive secretary of the council, a central service organization for hospitals. Mr. Markowitz will guide a program designed to acquaint the public with hospital services, facilities and costs. A former reporter for the *Cleveland Press*, Mr. Markowitz is a graduate of Western Reserve University and received a master's degree from the University of Pennsylvania.

Deaths

Edgar C. Hayhow, director of East Orange General Hospital, East Orange, N.J., since 1946, and a leader in the field of hospital administration, died August 24 after a three-month illness. He was 63. Mr. Hayhow was director of Paterson General Hospital, Paterson, N.J., for 16 years before going to East Orange, and he also served in administrative posts at Presbyterian, St. Luke's and Lenox Hill Hospitals, New York. In 1948 he was president of the American College of Hospital Administrators; he had been a regent for 12 years prior to that. He was a former first vice president and trustee of the American Hospital Association.

Bruce W. Dickson Jr., administrator of Bethany Hospital, Kansas City, Kan., for 10 years, died of a heart attack August 11. He was 35. A past president of the Mid-West Hospital Association, Kansas Hospital Association, and the Kansas City Area Hospital Council, Mr. Dickson at the time of his death was a member of the Kansas City Area Hospital Association's board of directors, the Blue Cross board of trustees, Blue Cross executive committee, and was active in numerous other committees.

Dr. Arthur S. Risser, president of the board of trustees of the Oklahoma Blue

(*Continued on Page* 168)

Does OXYGEN THERAPY support itself in your hospital?

If your present oxygen therapy is a liability, LINDE can help you make it self-supporting—even an asset. With more than 25 years of experience in the hospital field, LINDE has shown hundreds of hospitals how to bring paying efficiency to oxygen administration.

1. A LINDE specialist studies the conditions under which oxygen is administered in a hospital.
2. He makes recommendations for correcting any faulty practices that are found and assists in carrying out these recommendations.
3. He works with the business office to establish a system of charges for oxygen therapy that are fair to both the patient and the hospital.

To start the ball rolling in your hospital, just call your LINDE distributor, or write your nearest LINDE office.

LINDE COMPANY
Division of Union Carbide Corporation
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In Canada: Linde Company, Division of Union Carbide Canada Limited.

The terms "Linde" and "Union Carbide" are registered trade-marks of Union Carbide Corporation.

of the hospital team!

seen in the advanced engineering of our Model 25 Oxygen Tent.

Clinical tests of the Model 25 have indicated oxygen concentrations of 68% at 10 lpm. This high efficiency constantly assures the patient of the oxygen prescribed. Blower and motor are separated, ductwork between chamber and hood are eliminated to help prevent oxygen or temperature loss.

A simple adjustment of the thermostat insures stability of both temperature and humidity. The special non-cycling refrigeration unit holds temperature within one degree at all times.

Larger, low-speed blower, and a continuously running refrigerator make sure of quiet operation. There is no "on-off" switching or temperature variation to disturb patients.

Three frame heights accommodate all commercial bedrails. Four-inch ballbearing casters give mobility.

Should you desire further information, not only on the Model 25 Oxygen Tent, but also on our extensive line of oxygen therapy apparatus, please request Catalog 2180-OT.

OHIO PRODUCTS

MEDICAL GASES • THERAPY OXYGEN
CENTRAL PIPELINE SYSTEMS
ANESTHESIA AND ANALGESIA APPARATUS
OXYGEN THERAPY AND RESUSCITATION EQUIPMENT
STERIL-BRITE FURNITURE • SURGICAL SUTURES AND NEEDLES
STILLE SURGICAL INSTRUMENTS

OTHER OHIO AIDS FOR OXYGEN THERAPY

THE OHIO-JET HUMIDIFIER

A dual principle of jet action, plus bubble-through, is incorporated into the Ohio-Jet Humidifier, to produce maximum humidification in oxygen therapy. A jet stream of oxygen aspirates the water into a fog in the truly unbreakable polyethylene bottle; the oxygen fog then bubbles through surrounding water producing additional humidification. A special safety feature causes a whistle to sound if the delivery of oxygen to the patient is obstructed, even if the flow is set as low as three lpm. For information request Bulletin 4759.

"OHIO 100" NON-REBREATHING TYPE OXYGEN THERAPY MASK

For the patient's comfort, the face piece of the new "Ohio 100" Non-Rebreathing Mask is made of soft latex rubber, styled to conform to the face and free of pressure contact points. Dead space is minimized, and resistance to the patient's expired breath through the exhalation valve is negligible. If aerosol therapy is prescribed, the "Ohio 100" Mask can be quickly converted for this purpose.

OHIO OXYGEN DILUTER

To insure that the patient receives the prescribed amount of oxygen and required volume of air for ventilation, a special accessory has been designed for the "Ohio 100" Non-Rebreathing Mask. You can adjust desired mixture of pure oxygen and air from a low of 40% to a high of 95% oxygen. Once a percentage of oxygen concentration has been set, the flow may be adjusted or changed without affecting this concentration.

NEW CHILD-SIZE DISPOSABLE K-S MASK

To alleviate anxiety in children regarding oxygen therapy, a special child-size in the popular K-S Disposable Mask has been designed. A bright red spaceman and rocket ship are imprinted on the Kiddie Space Mask to stimulate the idea of a game in the child's mind.

The child-size K-S mask incorporates the features of the adult size. It allows ease of respiration and a deep rebreathing bag arrangement conserves oxygen. A patented porting arrangement prevents carbon dioxide build-up in mask bag or mask. Since this mask is worn by only one patient, time-consuming sterilization processes are eliminated. These transparent plastic masks are easily shaped to fit snugly but lightly on the face. For information request Bulletin 4762.

OHIO "Service is Ohio Chemical's Most Important Commodity"

Ohio Chemical

OHIO CHEMICAL & SURGICAL EQUIPMENT CO.
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Ohio Chemical Pacific Company, Berkeley 10, Calif.
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At the frontiers of progress you'll find **An Air Reduction Product** . . . **Ohio:** Medical Gases and hospital equipment • **Airco:** Industrial gases, welding and cutting equipment, and acetylenic chemicals • **Pureco:** Carbon dioxide, liquid, solid ("Dry-Ice") • **National Carbide:** Pipeline acetylene and calcium carbide • **Colton Chemical:** Polyvinyl acetates, alcohols and other resins. AIRCO

(*Continued From Page* 164)

Cross Plan, died in July at the age of 80. He formerly was the owner of Blackwell General Hospital, Blackwell, Okla., and he was a fellow of the American College of Surgeons.

P. Arthur Capitanelli, assistant administrator for professional services at Presbyterian Hospital, Chicago, died August 30 after he was stabbed by a 14 year old neighbor youth who broke into the Capitanelli home at night. Mr. Capitanelli, who had been associated with Presbyterian since January 1955, was 37.

Maine Hospital Institute Stresses Team Approach

(*Continued From Page* 146)

nurse and the doctor received attention in a session in which representatives from those professional ranks participated. On another occasion ways and means for establishing better doctor-trustee-administrator relationships were defined.

Assisting as members of the faculty were Phyllis E. Caswell, nurse consultant, Bingham Associates, Boston; Mrs. Edward Conquest, past president, State Hospital Auxiliaries, Eastern Maine General Hospital, Bangor; Dr. Jean A. Curran, consultant to the William Bingham 2d Trust for Charity, Boston; the Rev. Hartwell Daley, Pleasant Street Methodist Church, Waterville; Mother Elizabeth, administrator, Madigan Memorial Hospital, Houlton, Maine; A. Galen Eustis, vice president, Colby College; Mrs. Eleanor G. Gee, dietitian, Maine Medical Center, Portland; Margaret Giffin, director, department of hospital nursing, National League for Nursing, New York; Alice Grant, administrator, Henrietta D. Goodall Hospital, Sanford, Maine; Frederic LeRocker, director, Sloan Institute of Hospital Administration, Cornell University, Ithaca, N. Y.; Edward J. McGeachey, medical social service director, Maine Medical Center, Portland; Herluf V. Olson Jr., assistant to the director, Rhode Island Hospital, Providence; Rowena Walden, physical therapist, Maine Medical Center, Portland, and Dr. Charles F. Wilinsky, hospital consultant and trustee, Beth Israel Hospital, Boston.

Raymond P. Sloan, chairman of the board, The Modern Hospital Publishing Company, New York, served as director of the institute, and Pearl R. Fisher, R.N., administrator, Thayer Hospital, Waterville, as assistant director.

Colors shown above: Gunmetal; Carnation Pink; Mustard; Easton Tan; Eureka Brown; Sand; Evanston Red; Exeter Red; Tangerine; Everglades Green; Excelsior Green; Black; Englewood Green; Cerulean Blue; White.

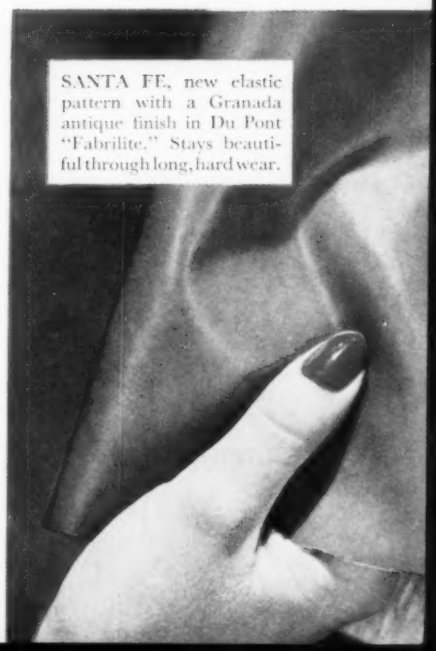
Announcing a new Du Pont Fabrilite® pattern featuring House and Garden colors

VINYL UPHOLSTERY

Long-wearing, elastic "Fabrilite" in stay-clean pastels and deep tones for every décor . . .

Fifteen captivating colors—House and Garden pastels and other rich, deep tones—are yours to choose from in Santa Fe, the new pattern in Du Pont "Fabrilite"* vinyl upholstery. "Fabrilite" is not only beautiful, but also practical, for it resists soil and wear, cleans easily with a damp, soapy sponge. "Fabrilite" keeps your furniture looking bright and new for years . . . gives you soft seating comfort, too. Find out about the wonderful range of colors in Santa Fe . . . ask your distributor for this new pattern in Du Pont "Fabrilite."

*"Fabrilite" is Du Pont's registered trademark for its elastic-supported vinyl upholstery.



SANTA FE, new elastic pattern with a Granada antique finish in Du Pont "Fabrilite." Stays beautiful through long, hard wear.

◀ CONTACT YOUR NEAREST DISTRIBUTOR SHOWN ON OPPOSITE PAGE.

There's no vinyl upholstery like DU PONT

REG. U.S. PAT. OFF.

BETTER THINGS FOR BETTER LIVING . . . *THROUGH CHEMISTRY*

COMING EVENTS

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Schroeder Hotel, Milwaukee, Oct. 7-10.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS. Regional Membership Conference: Region 9, Chicago, Nov. 11-15.

AMERICAN COLLEGE OF OSTEOPATHIC HOSPITAL ADMINISTRATORS, St. Louis, Oct. 26.

AMERICAN DIETETIC ASSOCIATION, Dinner Key Auditorium, Miami, Fla., Oct. 22-25.

AMERICAN HOSPITAL ASSOCIATION INSTITUTES: Operating Room Administration, Hotel President, Kansas City, Mo., Oct. 7-10; Insurance for Hospitals, Hotel Statler, Hartford, Conn., Oct. 9, 10. Medical Record Procedures Review for Department Personnel and Administrators, Hilton Hotel, Albuquerque, N.M., Oct. 21-23; Evening and Night Service Administration, Mission Inn, Riverside, Calif., Oct. 28-Nov. 1. Disaster Planning, Hotel George Washington, Jacksonville, Fla., Oct. 30-Nov. 1. Hospital Auxiliary Leadership, Hotel Statler, Hartford, Conn., Nov. 4, 5.

AMERICAN NURSING HOME ASSOCIATION, Ambassador Hotel, Atlantic City, N.J., Oct. 7-10.

AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION, St. Louis, Oct. 27-30.

BRITISH COLUMBIA HOSPITALS' ASSOCIATION, Vancouver Hotel, Vancouver, Oct. 15-18.

CALIFORNIA HOSPITAL ASSOCIATION, Lafayette Hotel, Long Beach, Oct. 30-Nov. 1.

COLORADO HOSPITAL ASSOCIATION, Hotel Denver, Glenwood Springs, Oct. 10, 11.

CONNECTICUT HOSPITAL ASSOCIATION, Conn. Light & Power Co., Berlin, Conn., Nov. 13.

ILLINOIS HOSPITAL ASSOCIATION, Hotel Abraham Lincoln, Springfield, Dec. 5, 6.

INDIANA HOSPITAL ASSOCIATION, Student Union, Univ. of Ind. Medical Center Campus, Indianapolis, Oct. 9, 10.

INSTITUTE FOR HOSPITAL ACCOUNTANTS, Ritz-Carlton Hotel, Atlantic City, N.J., Oct. 21, 22.

KANSAS HOSPITAL ASSOCIATION, Broadview Hotel, Wichita, Nov. 14, 15.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Shoreham Hotel, Washington, D.C., Nov. 6-8.

MISSISSIPPI HOSPITAL ASSOCIATION, Hotel Buena Vista, Biloxi, Oct. 9-11.

NEBRASKA HOSPITAL ASSOCIATION, Cornhusker Hotel, Lincoln, Oct. 17, 18.

NEW ENGLAND HOSPITAL ASSEMBLY, Instructional Conferences, Hotel Statler, Boston, Oct. 17, 18.

ONTARIO HOSPITAL ASSOCIATION, Royal York Hotel, Toronto, Oct. 28-30.

OREGON ASSOCIATION OF HOSPITALS, Eugene Hotel, Eugene, Nov. 4, 5.

SOUTH DAKOTA HOSPITAL ASSOCIATION, fall meeting, Sheraton Cataract Hotel, Sioux Falls, Oct. 15, 16.

VERMONT HOSPITAL ASSOCIATION, Long Trail Lodge, Pico Peak, Rutland, Oct. 18.

VIRGINIA HOSPITAL ASSOCIATION, Hotel Chamberlin, Old Point Comfort, Nov. 15, 16.

1958

ALABAMA HOSPITAL ASSOCIATION, Hotel Stafford, Tuscaloosa, Jan. 23, 24.

AMERICAN COLLEGE OF SURGEONS, Joint Nurses-Surgeons Meeting, Commodore Hotel, New York, March 3-6.

ASSOCIATION OF OPERATING ROOM NURSES, Bellevue-Stratford Hotel, Philadelphia, Feb. 10-12.

ASSOCIATION OF WESTERN HOSPITALS, Civic Auditorium, San Francisco, April 21-24.

CAROLINAS-VIRGINIAS HOSPITAL CONFERENCE, Hotel Roanoke, Roanoke, Va., April 24, 25.

CATHOLIC HOSPITAL ASSOCIATION, Atlantic City, N.J., June 21-26.

COMITÉ DES HOPITAUX DU QUEBEC, Montreal Show Mart, Montreal, Que., June 25-27.

GEORGIA HOSPITAL ASSOCIATION, Ralston Hotel, Columbus, Feb. 20,21.

LOUISIANA HOSPITAL ASSOCIATION, Bellemont Motor Hotel, Baton Rouge, March 20-22.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Shoreham Hotel, Washington, D.C., Nov. 3-5.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, N.J., May 21-23.

MID-WEST HOSPITAL ASSOCIATION, Municipal Auditorium, Kansas City, Mo., March 24-26.

NEW ENGLAND HOSPITAL ASSEMBLY, Hotel Statler, Boston, March 24-26.

OHIO HOSPITAL ASSOCIATION, Netherland-Hilton Hotel, Cincinnati, March 10-13.

SOUTHEASTERN HOSPITAL CONFERENCE, Hotel Fountainbleau, Miami Beach, Fla., May 14-16.

TEXAS HOSPITAL ASSOCIATION, Statler-Hilton Hotel, Dallas, May 5-8.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, April 28-30.

UPPER MIDWEST HOSPITAL CONFERENCE, Minneapolis Auditorium and Leamington Hotel, Minneapolis, May 14-16.

WEST VIRGINIA HOSPITAL ASSOCIATION, Daniel Boone Hotel, Charleston, Oct. 15-18.

"Specialist"®

COLOR-CAST Plaster Bandages

made with

PURE, SAFE, NON-TOXIC COLORS

Bright colors are ideal for all casts on children — soft yellow and flesh tones appeal to many adults.
SPECIALIST Color-Cast Bandages may be used throughout the cast or for the final covering layers of any white cast.

Available in 3" and 4" widths in either assorted colors or all flesh-tone. Assortments contain three red, three blue, three yellow and three flesh-tone.

Johnson & Johnson

this is ABC month

about audits

October is ABC month. ABC stands for Audit Bureau of Circulations, an association of publishers, advertisers and advertising agencies. Its purpose is to audit periodical circulations on a regular and continuing basis. The MODERN HOSPITAL became a charter member of ABC when it was established in 1914.

You read a lot of magazines and newspapers which are members of ABC. The most impelling reason for their being members is that ABC provides facts about their circulation which enable advertisers to judge their value as advertising media.

There is an equally important by-product of ABC membership that is of value to you. The ABC audit necessitates keeping detailed records of subscription sales. These records tell the publisher and the editor what kinds of readers the periodical attracts, how many people buy the periodical and by what means they are induced to buy, and how many of them keep on buying it year after year. This constant record of subscription sales is a valuable aid in evaluating editorial service.

The ABC audit serves the editor and publisher, and therefore the reader, in much the same way that a medical audit serves the hospital, its administration and therefore the patient.

As you know, hospital medical audits measure the quality of medical service rendered by the hospital. They provide a continuing check of the performance of the medical and surgical staff. With the yardstick available, hospital administrators and staff members are enabled and encouraged to maintain high standards. Hospitals which maintain these standards render better service to the patient.

Like medical audits, ABC audits are undertaken on a voluntary basis. ABC members join the organization of their own volition, submit their circulation records to audit of their own volition, and of their own volition, keep the detailed records required.

ABC audits do not, of themselves, create editorial excellence—any more than medical audits create hospital excellence. Both perform the useful function of measurement and it is continuing measurement which provides the basis for evaluation of performance and a guide to ways and means for improvement.

The MODERN HOSPITAL believes that this kind of performance measurement is, therefore, important to you—and is proud to use this space to tell you about it.

AUDITED PAID CIRCULATION ABC

The Modern Hospital

CRA

New...the first and only bedpan washer with a "no-drip" nozzle

Doesn't have to be drained after using

You know what happens if a nurse or nurse's aide forgets to drain the ordinary bedpan washer after she's finished with it. Water drips over the floor and someone has to take time to clean it up.

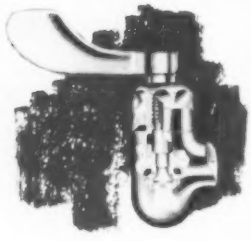
But not with the Crane bedpan washer. It meets all the latest plumbing sanitary requirements and yet doesn't drip. The secret is a spray nozzle with an exclusive "no-drip" feature. It stops the dripping before it has a chance to start.

For complete information see your Architect or Crane Representative. Find out how Crane specialization can save your hospital time and money.

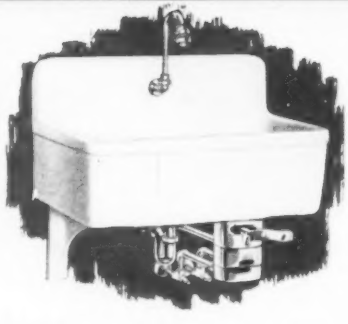
CRANE CO. 836 South Michigan Ave. Chicago 5, Illinois

VALVES • FITTINGS • PIPE • PLUMBING • KITCHENS • HEATING • AIR CONDITIONING

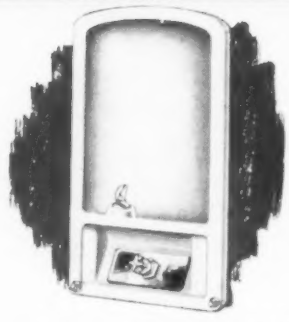
Do You Have These Other Crane Exclusives in Your Hospital?



Dial-ese controls on all plumbing fixtures. *Minimize dripping. Close with water pressure. Threads permanently lubricated. Working unit replaced in about 10 seconds.*



Duraclay. *A special vitreous glazed earthenware for large hospital fixtures. Won't crack or craze under thermal shock. Available in white or seven Crane colors.*



Corridor Drinking Fountain. *Fully recessed type leaves hall area clear . . . nothing to clean under. Available with single Wal-Pak or central water chiller for up to sixty installations.*

Book Review

HOSPITALS AND PUBLIC HEALTH NURSING SERVICES PLAN BETTER PATIENT CARE. *Report of national conference sponsored by the Department of Public Health Nursing and the Department of Hospital Nursing of the National League for Nursing. Pp.* 39. $1.

"Those involved with the problem of increasing the number of referrals between home nursing agencies and hospital nursing services have here a guide that should prove most valuable.

"It would be my impression that there is no new or extraordinary bit of information or idea that is missing from the earnest consciousness of the laborers in the health field. What is lacking, and perhaps long past due, is a recognition of the failure of application of this knowledge," says George A. Silver in the paper he presented at the Chicago conference, which is printed in this pamphlet.

"Better patient care is wanting not because of something we don't know or don't have. Better patient care is wanting because of something we don't do," Mr. Silver continues.

In developing his theme, Mr. Silver recommends a discharge planning conference between the doctor, hospital nurse, visiting nurse, social worker and therapists in order to make possible the two-way communication he feels is vital. Such conferences have been used for many years in the fields of tuberculosis and in mental institutions.

In the second of three papers reprinted in the pamphlet, Doris Schwartz describes and illustrates a referral system for use between the hospital and the public health nursing service.

She points out that referral is the duty of the nurse and that, properly used, the system would develop to the point where failure to refer a patient would indicate only that the patient is not a candidate for such care.

The illustrations used with this paper are particularly recommended since they constitute excerpts from an actual case history.

The third paper published in the booklet is a scholarly discussion of communication, well done by Bess Sondel.

The booklet has a preface and two introductory chapters, one on planning between nursing services and the other taking up community planning.

FORT HOWARD PAPER TOWELS

dry more hands dryer

...because of controlled wet strength

We call it "greater drying power."

It results from Controlled Wet Strength which keeps wet towels strong, firm, soft. One towel will soak up all the water on a pair of dripping hands. And that means economy for you.

What's more, Stabilized Absorbency helps keep this drying power as the towels age—they're good to the last towel in the package. And because they're Acid Free, Fort Howard Towels are gentle on hands.

That's why—from factories to offices, from institutions to schools—Fort Howard Towels dry more hands dryer than any other paper towels.

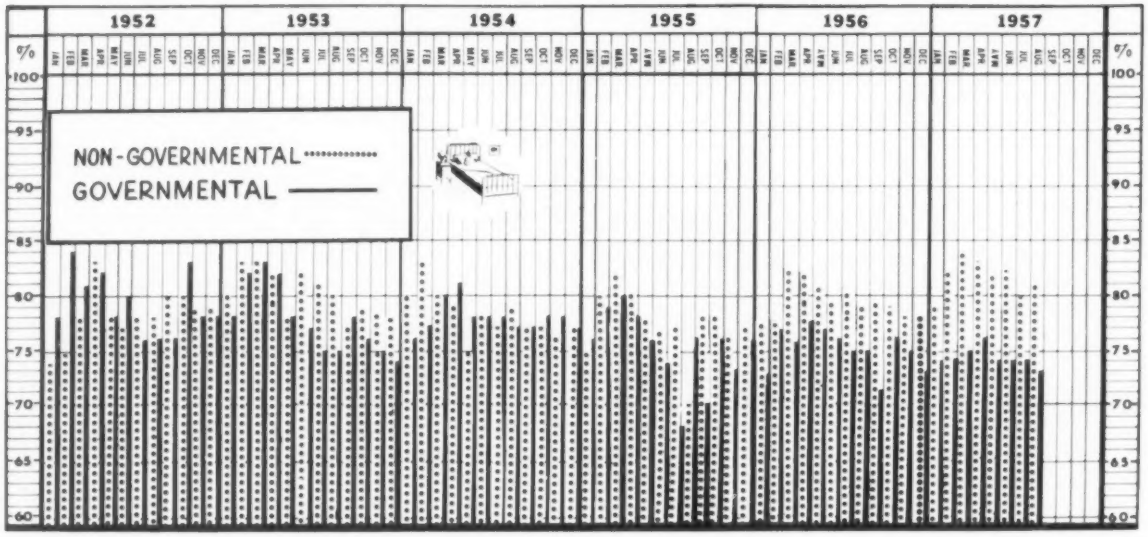
Select one of Fort Howard's 27 grades and folds for your washroom. Remember—Fort Howard Towels can fill any cabinet at any price. Call your Fort Howard distributor salesman for more information and samples . . . or write Fort Howard Paper Company, Green Bay, Wisconsin.

Fort Howard Paper Company

Green Bay, Wisconsin

America's most complete line of paper towels, tissues and napkins

Construction Totals $909,828,502 for Year to Date



Occupancy of voluntary hospitals continued to rise in August while that of government institutions declined somewhat. The figure for voluntary hospitals was 80.5, as against 79.9 in August 1956; government hospitals reported occupancy of 72.8 per cent in August of this year, compared to 75.3 per cent a year ago.

Building construction took a spectacular leap in the period between August 5 and September 16, with 238 projects reported at a total cost of $321,574,690. This brings the year's total to date to $909,828,502. Last year the total was $694,271,101. Of the 238 projects reported since August 5, 51 are new hospitals.

Wash 'n Dri

The miracle moist Towelette!

WASHES HANDS AND FACE WITHOUT WATER, SOAP, TOWEL

RRW

SAVE THOUSANDS OF DOLLARS IN EXPENSIVE BEDSIDE CARE

Sealed, saturated Wash 'n Dri tissues save nursing time—cleanse, cool, soothe patients.

1. Hermetically sealed, saturated, antiseptic tissues for bedside use and patients' meal trays.

2. Save attendants' and nurses' time for washing up, cooling, soothing patients.

3. Easy to open, no towel needed, air-dries in seconds, leaves skin smooth, soft clean.

4. Useful for bathing children during fever, cooling and comforting patients after surgery, childbirth, and dental extractions.

Used in hundreds of hospitals from coast to coast

WRITE FOR SAMPLES AND MORE INFORMATION ABOUT

WASH 'N DRI

TO: WASH 'N DRI, CANAAN, CONNECTICUT
Please send me samples of WASH 'N DRI

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R. R. WILLIAMS, INC., CANAAN, CONN.

The Berkshire Eagle—April 9
PITTSFIELD, MASS.

Wash Tissues Given Trial At St. Luke's

Wash basins, water pitchers, soap, washcloths and hand towels have been replaced at St. Luke's Hospital by matchbook-sized alcohol-dampened tissues.

Sister Superior Marie Reparatrice, hospital administrator, said the tissues, known as Wash 'n Dri, are being used both as a time-saver for hospital employes and as a convenience for the patients.

Packed in aluminum foil, the towelettes are easily unfolded to 6 by 8 inch size. The alcohol solution cleans, cools, refreshes and dries by evaporation.

Patients get their daily bath in the usual way, but they much prefer Wash 'n Dri for the early morning washup, after meals, after reading newspapers and whenever they want to feel clean and cool, the administrator said.

"In addition to saving countless nursing hours, the patients are happier with the new service," Sister Superior said. St. Luke's is one of the first hospitals in the country to adopt the system.

Wash 'n Dri is made by R. R. Williams Inc. of Canaan, Conn. The towelettes are particularly handy in water shortages and other emergencies.

Let's Face It...

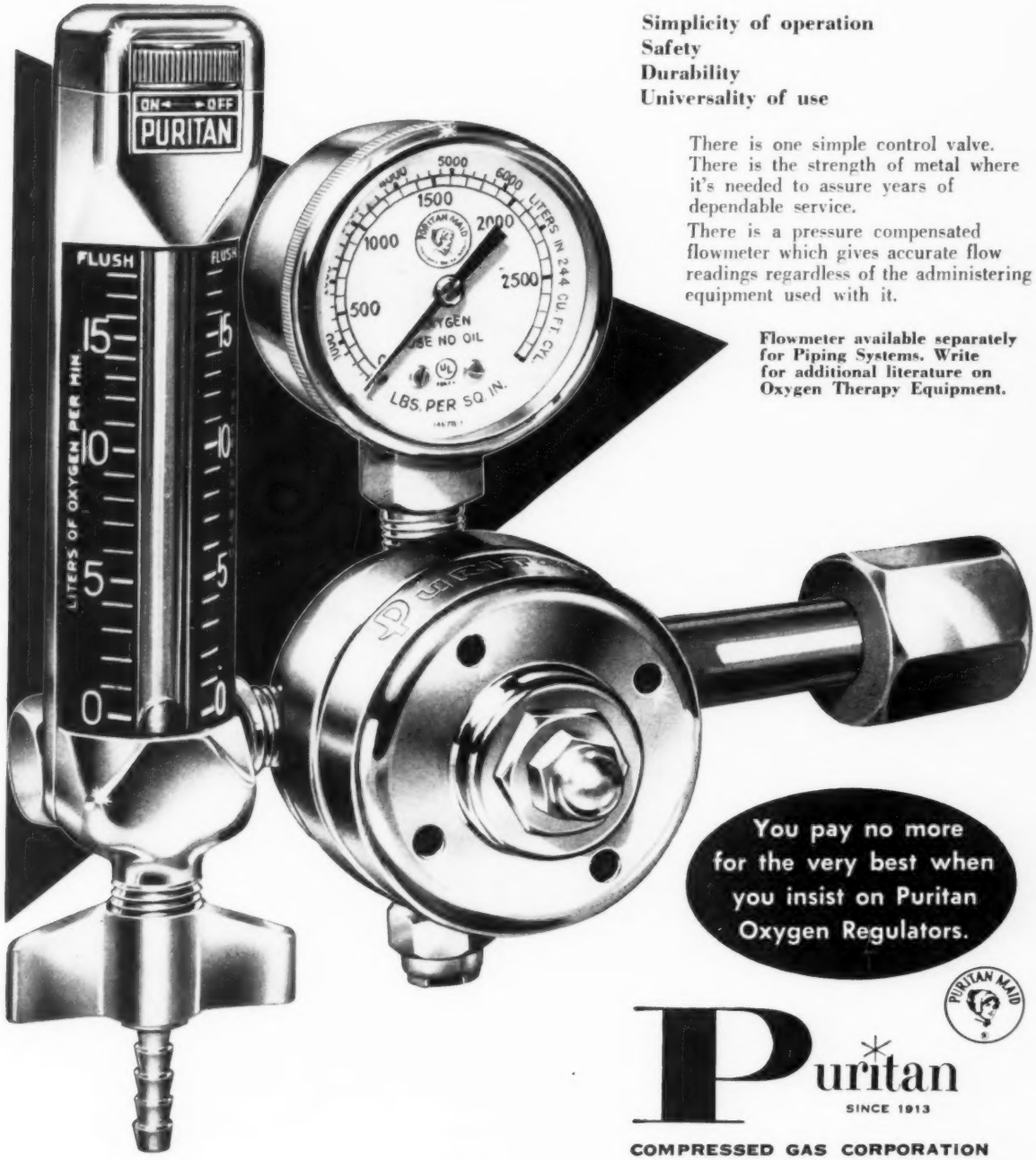
Of the many things that can be said about an Oxygen Regulator—here are the points that really count:

Simplicity of operation
Safety
Durability
Universality of use

There is one simple control valve. There is the strength of metal where it's needed to assure years of dependable service.

There is a pressure compensated flowmeter which gives accurate flow readings regardless of the administering equipment used with it.

Flowmeter available separately for Piping Systems. Write for additional literature on Oxygen Therapy Equipment.



You pay no more for the very best when you insist on Puritan Oxygen Regulators.

Puritan
SINCE 1913

COMPRESSED GAS CORPORATION
KANSAS CITY 8, MO.

PRODUCERS OF MEDICAL GASES AND GAS THERAPY EQUIPMENT

Hospitals use

NIBROC® TOWELS

more than any other paper towel

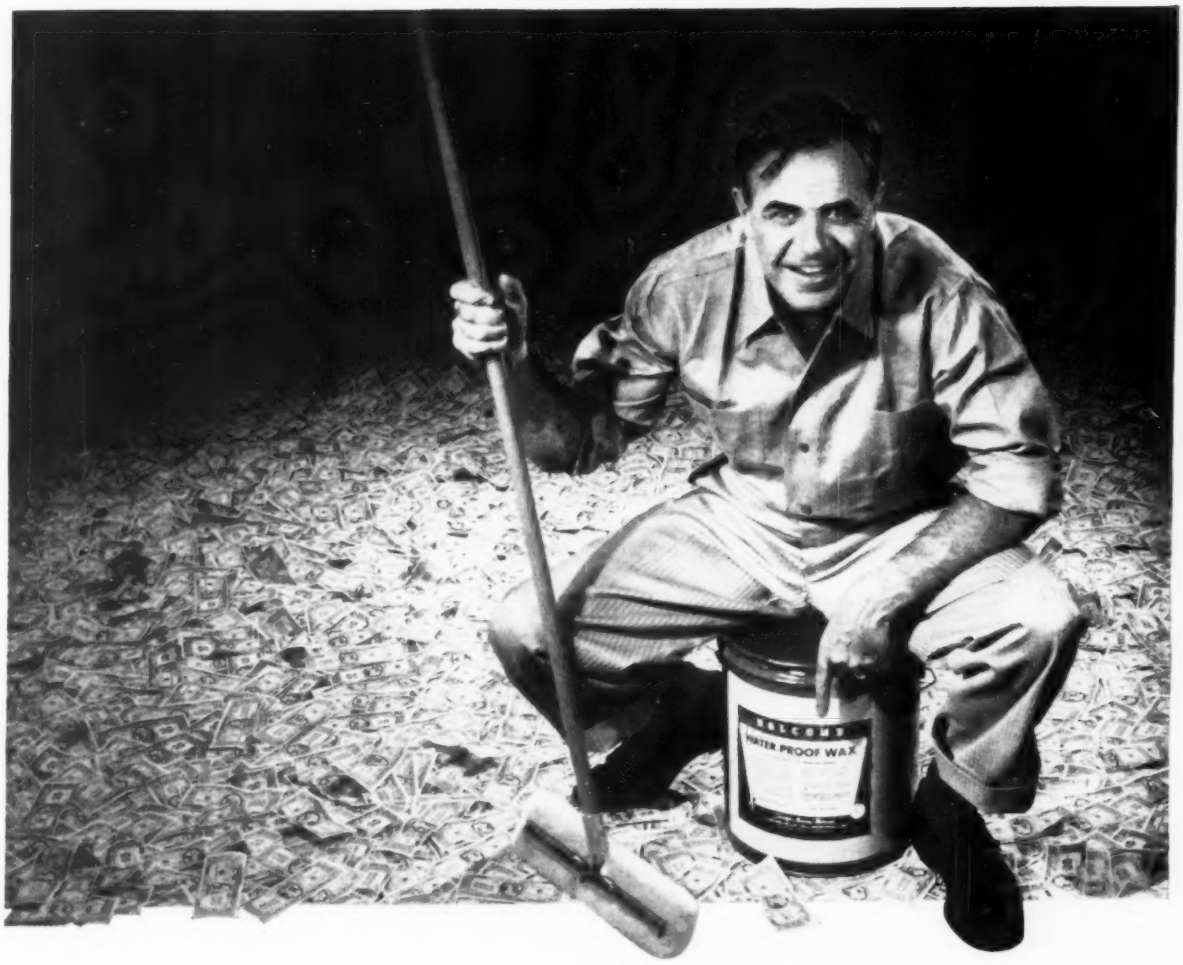
And today hospitals have even better reasons to buy Nibroc Towels. Because the *new* Nibroc white towel – now available – is whiter than ever – result of an exclusive Brown Company "white magic" bleaching process. Nibroc Towels in natural shade are vastly improved too, by new manufacturing techniques. Nibroc Towels are soft, sanitary, absorb water instantly.

Nibroc was the first and is still the finest wet-strength towel. *Economize with Quality.* You can save money if you buy Nibroc Towels with Nibroc Sofwite® and Softan® tissue. For information call your dealer listed under "Paper Towels," or write us at Dept. NP-10, 150 Causeway Street, Boston 14, Mass.

BROWN COMPANY

Find Your Distributor in The 'Yellow Pages'

Other NIBROC Quality Products: INDUSTRIAL WIPERS . WINDSHIELD WIPERS . KOWTOWLS . WALL, FLOOR and RECESSED CABINETS



"This stuff makes our floors look like a million bucks!"

Not only that, Holcomb customers say WATER-PROOF WAX saves them plenty of bucks, too.

Holcomb WATER-PROOF lasts 2 to 5 times as long as ordinary waxes. Even if it lasted only twice as long, figure it this way:

Most companies pay for about 110 man-hours of work (sweeping, mopping, scrubbing, waxing, buffing) per drum of wax used. Say you ordinarily used four drums of wax a year—with WATER-PROOF you'll need only two. That saves 220 man-hours, or, at a reasonable hourly rate, somewhere between $350 and $500 per year on waxing labor costs alone!

And since you only wax half as often with WATER-PROOF, you'll cut wax consumption in half. Actually, you'll *make* money . . . for you're saving more per year than you'd spend on WATER-PROOF. To cut your maintenance costs, ask your Holcombman about Holcomb WATER-PROOF WAX.

HOLCOMB SCIENTIFIC CLEANING MATERIALS

J. I. HOLCOMB MFG. CO., INC. · 1601 BARTH AVENUE · INDIANAPOLIS, INDIANA
Hackensack · Dallas · Los Angeles · Toronto

stick 'em up!

IPCO

STIK-BAG

PAT. PEND.

FOR BEDSIDE WASTE DISPOSAL

NO costly cumbersome wire frame holders

NO unsightly brown paper bags

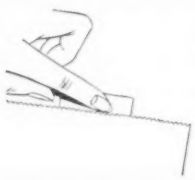
NO pin-hole damage to sheets

NO wasteful use of adhesive tape

The Ipco "STIK-BAG" is surprisingly economical in addition to its neatness, cleanliness and convenience. Usage has proven that it pays for itself many times over in savings on linens alone. "STIK-BAG" tabs on wherever you want it: to bed, cabinet, wall, bassinette stand, in the nursery, etc.

• FREE SAMPLES ON REQUEST •

INSTITUTIONAL PRODUCTS IPCO CORPORATION



TO APPLY, peel off protective white paper from tab. "STIK-BAG" adheres firmly to wood, glass, metal, etc. Peels off easily without marring surface.

INSTITUTIONAL PRODUCTS CORPORATION • 161 SIXTH AVE. • NEW YORK 13, N. Y.

BRANCH OFFICE: 9109 Sovereign Row, Dallas 19, Texas

new! safe!

EMERGENCY OXYGEN and RESUSCITATION UNIT

by McKesson

A new, easily-portable, perfectly-balanced unit.
Many outstanding safety and economy features.
Uses either D or E size cylinders.

New, improved flow-valve graduated with adjustable zero position, always indicates approximate flow rate.
Impossible to open control-valve more than one turn.

No danger of excessive flow-rate, should valve be left open when attaching full cylinder. Pin-indexed yoke precludes possibility of attaching improper gas.

For resuscitation, squeezing re-breathing bag forces oxygen into patient's lungs.

many other important features

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POSITIONS WANTED

ADMINISTRATOR—9 years, 250-bed general hospital; chief accountant; administrative assistant, 4½ years assistant; experience embraces all phases of hospital administration, considerable direct relations with medical staff; planning, equipping, staffing new hospital; Member ACHA-34. Apply MW 202, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

ADMINISTRATOR or ASSISTANT—Management specialist, age 37, with experience in sales, personnel, office procedures, purchasing, maintenance and repairs, etc. B.A. Degree, Monmouth College; fifteen years experience and interest in health field and administration, fund raising, and community problems; married, two children; finest references and credentials; will relocate anywhere. Reply Mr. Maurice A. Garland, 723 East Euclid Avenue, Monmouth, Illinois. Telephone 887.

CLINIC MANAGERSHIP—Wanted by former public accountant with hospital and industrial background; presently employed; age 47, married, minimum salary $8000. Apply MW 203, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

PERSONNEL OFFICER—Female; excellent industrial and hospital experience; seven successful years of organizing and managing personnel department for 400-bed hospital; interested in general hospital; size not important; top references. Apply MW 206, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

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ADMINISTRATOR—Medical; has had two important administrative assignments since 1940; in both instances performance considered outstanding; highly regarded in the field; F.A.C.H.A.

ADMINISTRATOR—M.A. (Hospital Administration); 3 years, assistant, 400-bed hospital; seven years, director, 300-bed teaching hospital; F.A.C.H.A.

ADMINISTRATOR—Professional nurse; B.S. in Nursing; M.P.H. (Hospital Administration); three years, assistant administrator, 250-bed general hospital.

COMPTROLLER—B.S.; accounting manager (five years), comptroller (two years), 550-bed hospital; two years, director department, 1000-bed hospital.

FOOD SUPERVISOR—B.S. (Major: Institutional Management & Home Economics); 10 years' experience.

PATHOLOGIST—M.S. (Pathology); Diplomate; FCAP; six years, director, pathology, 350-bed teaching hospital; nine years, director, laboratories, hospital group; 800 beds.

MEDICAL BUREAU—*Continued*

RADIOLOGIST—Diplomate; M.S. (Radiology); four years, associate radiologist, large teaching hospital, on faculty medical school.
Our Booth at the American College of Surgeons Meeting is No. 336.

INTERSTATE MEDICAL PERSONNEL BUREAU

Miss Elsie Dey, Director
332 Bulkley Building
Cleveland, Ohio

ADMINISTRATOR—Age 36 years; M.S. Degree, Hospital Administration, Northwestern University. 9 years administrator, 175-bed hospital, midwest.

BUSINESS MANAGER—Age 45 years; Degree, Business Administration; comptroller, 300-bed Pennsylvania hospital, 4 years; past 5 years Administrator, 225-bed hospital; prefers reorganizational program.

COMPTROLLER—Age 35; presently chief accountant, 400-bed Ohio hospital; prefers west, mid-west.

ASSISTANT ADMINISTRATOR—Business Manager; M.S. Degree; Hospital Administration; previous experience, public and hospital accountant, past three years, purchasing agent—assistant administrator.

DIRECTOR OF NURSING—B.S. Degree; 5 years experience, director, nursing service; 4 years director, school of nursing; 175-bed hospital, Pennsylvania.

EXECUTIVE HOUSEKEEPER—College credits; 1 year's training, mid-western hospital; past 3 years, director-housekeeping, 225-bed hospital.

SHAY MEDICAL AGENCY

Blanche L. Shay, Director
55 East Washington Street
Chicago 2, Illinois

ADMINISTRATOR—Age 47; college graduate; 8 years experience as administrator in 3 hospitals, 75, 80, 200-beds; 4 years as assistant comptroller 400-bed hospital.

ADMINISTRATOR—Age 33; M.S. degree in Hospital Administration, Northwestern University, Evanston, Ill.; B.S. degree Management and Marketing, University of Illinois; excellent background in hospitals as assistant administrator, consultant, administrative assistant, etc.

ASSISTANT ADMINISTRATOR—Age 32; M.S. degree Hospital Administration, University of California; 3 years in hospitals as administrative intern, teaching assistant and administrative resident; excellent references.

SUPERINTENDENT OF BUILDINGS AND GROUNDS—Chief engineer; Age 53; 25 years experience in hospitals as chief and safety engineer.

CHIEF PHARMACIST—Age 42; B.S. degree Pharmacy; University of Kentucky. M.S. degree Pharmacy University of California; 7 years experience, as hospital pharmacist—last two as chief in 330-bed hospital.

(Continued on page facing 185)

SHAY—*Continued*

PERSONNEL DIRECTOR—Age 49; A.B. degree; 17 years experience in personnel work; last two years personnel director of large hospital—1200 employes.

COMPTROLLER—Age 37; B.S. in Accounting and Finance; 11 years hospital experience as comptroller, business manager.

POSITIONS OPEN

ANESTHETIST—Nurse; immediate opening 40 hour week; 5% increase after six months, after one year, two weeks vacation with pay. Apply MO 207, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

ANESTHETIST—Registered nurse experienced to complete staff of 3 serving 2 hospitals 16 miles apart; however, applicant will work primarily in 71-bed fully accredited air-conditioned hospital; hospital currently expanding to 135-beds; starting salary of $550 per month with liberal personnel policies; normal work week of 44 hours; hospital located in university city of 21,000. Write Jack B. Edmundson, Administrator, Doctors Hospital, Carbondale, Illinois.

ANESTHETIST—Nurse; for 36-bed modern hospital located in a pleasant mid-western town of 5,000; 2 weeks vacation and 12 days sick leave per year; salary open. Write Personnel Office, Sparta Community Hospital, Sparta, Illinois.

ANESTHETIST—Nurse; for obstetrics or surgery; salary open, three weeks vacation per annum, 12 days sick leave per annum, accumulative. Apply to Personnel Director, Methodist Hospital, 1600 West 6th Avenue, Gary, Indiana.

ANESTHETIST—Nurse; excellent working conditions; $450.00 per month with annual increases of $25.00 per month to maximum of $500.00; three weeks vacation after one year, minimum of two weeks sick leave; usual employee benefits; Lexington is located in "The Heart of the Bluegrass" famous for horse racing and tobacco industries, home of University of Kentucky and Transylvania College. Apply Assistant Administrator, Good Samaritan Hospital, South Limestone Street, Lexington, Kentucky.

ANESTHETIST—Nurse; male nurse preferred; immediate opening for anesthetist in private, non-profit hospital, 110 beds, new and modern hospital, communities of Ishpeming and Negaunee approximately 18,000 with a 40,000 population; trading area, iron ore mining is main industry; also year-round resort area with ample recreational facilities and is internationally known for winter sports; very good plane and railroad transportation; excellent school system; starting salary $450 and up. Write: Administrator, Bell Memorial Hospital, Ishpeming, Michigan.

ANESTHETIST—Nurse; for 250-bed general hospital; excellent working conditions and personnel policies; good starting salary. Write Mr. Bert Stajich, Assistant Administrator, Columbia Hospital, 3321 N. Maryland Avenue, Milwaukee 11, Wisconsin.

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In the room illustrated, the furniture colors are Simmons Natural with White, with Cherry Textolite tops. The upholstery is tough Naugahyde in a new Accent pattern. The bed is a Single-Action Vari-Hite by Simmons, equipped with hospital Beautyrest* mattress, made only by Simmons. All furniture designed by Raymond Spilman, A.S.I.D.

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ANESTHETISTS — Nurse: 260-bed general hospital; two anesthesiologists, twelve nurse anesthetists; all types surgery and gyn work; Accredited School of Anesthesia for nurses offers opportunity for clinical teaching, plus lecture experience if desired; 40 hour week includes call; call every fourth weekend; night anesthetist employed; overtime paid after 80 hours two weeks; starting salary $400.00 month, merit increases after 1st, 2nd, 3rd, 5th, 10th years; three weeks' vacation after 1st and 2nd years, four weeks thereafter; other fringe benefits; can accommodate to afternoon hours if applicant wishes to attend University to obtain degree. Contact H. Miller, Personnel Director, Northwestern Hospital, Minneapolis 7, Minnesota.

ANESTHETIST—Nurse; position open in 134-bed general hospital; salary and living conditions very desirable; room, laundry and insurance benefits furnished in addition to salary; location on the east side of St. Paul with convenient transportation to the downtown area; two other anesthetists on duty with a minimum amount of call. Write E. M. Garnett, Superintendent, Mounds Park Hospital, 200 Earl Street, St. Paul 6, Minnesota.

ANESTHETIST—Nurse; 435-bed general hospital doing surgical and obstetrical (500-350) anesthesia; both male and female anesthetists on staff; starting salary $400 with annual increments plus meals and laundry; complete maintenance if desired; night calls for week-end relief only 4 day week-end off once a month; 1 month paid vacation, sick leave granted, Social Security. Apply Akron General Hospital, Akron 7, Ohio.

ANESTHETIST — Nurse; female; excellent starting salary, merit increases, liberal fringe benefits, good hours; accredited hospital and surgeons limited to our staff. Apply to Elmer J. Berg, Business Manager, Gundersen Clinic, La Crosse, Wisconsin.

ANESTHETISTS — Nurse; AANA members, $400-$475 per month; 400-bed general hospital excellent working conditions, liberal personnel policies; T.O., 16 anesthetists and one anesthesiologist. Write Personnel Director, The Queen's Hospital, P. O. Box 614, Honolulu 9, Hawaii.

ASSISTANT DIRECTOR — Medical records department; immediate opening; must be registered or eligible for registration; 446-bed general hospital; good salary and personnel policies; opportunity to work with professional activity study. Write Mr. J. M. Dunlop, Administrator, Bridgeport Hospital, Bridgeport, Connecticut.

DIETITIAN—Therapeutic; member of A.D.A.; five day week; salary open; modern well-equipped dietary department, newly built. Apply Administrator, St. Margaret's Hospital, Inc., 834 Adams Avenue, Montgomery 5, Alabama.

(Continued on page 186)

DIETITIANS—1 assistant administrative; supervise and schedule employees; at least 2 years of personnel experience; 1 therapeutic, with some administrative duties; salary open; 466-bed hospital in desirable location. Write Personnel Department, Cedars of Lebanon Hospital, Los Angeles 29, California.

DIETITIAN—Therapeutic; Borgess Hospital, 340-bed general hospital; duties include cafeteria, therapeutic diet planning, patient contact, general supervising and teaching student nurses; a large full-time medical staff and house staff; salary open, progressive personnel policies. Apply Hospital Administrator, Borgess Hospital, Kalamazoo, Michigan.

DIETITIANS—Therapeutic; large teaching hospital, 6 units affiliated with Washington University School of Medicine; monthly staff salaries begin at $300 based on a 40 hour week; due to the need for more professional dietetic hours in the medical center, dietitians are allowed overtime work and are paid at an hourly rate based on monthly salaries; two weeks vacation; social security; Blue Cross. Apply, Director of Dietetics, Barnes Hospital, 600 South Kingshighway, St. Louis 10, Missouri.

DIETITIAN—Chief; A.D.A. member; experienced person will find a challenge and opportunity. Apply Director, The Buffalo General Hospital, Buffalo 3, New York.

DIETITIAN—Therapeutic; A.D.A. member, to supervise tray service, dietary personnel and counsel patients; no teaching required; hospital recently expanded to 450-beds, located in de-

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POSITIONS OPEN

DIETITIAN—Therapeutic; A.D.A. member, to supervise tray service, dietary personnel and counsel patients; no teaching required; hospital recently expanded to 450-beds, located in desirable residential district; approved by Joint Commission; dietary facilities entirely new and air conditioned; dietetic program integrated with approved school of nursing, affiliated with Medical Research Institute; 40 hour week, broad personnel policies and benefits; salary open. Apply Miss Rosemary E. Brown, Director of Dietetics, The Toledo Hospital, Toledo 6, Ohio, or call Greenwood 2-1121.

DIRECTOR OF NURSING—Progressive State hospital with affiliate nursing program; starting salary dependent upon academic qualifications, experience and personal qualifications; starting range from $4300 to $7800 plus self maintenance; liberal sick time, holidays, paid vacation. Write to Dr. J. O. Cromwell, Superintendent, Mental Health Institute, Independence, Iowa.

DIRECTOR OF EDUCATION—NLN accredited diploma school; basic sciences taught Amarillo College; total enrollment 100; forty hour week, salary commensurate with qualifications; hospital JCAH; 230-beds; expansion program in process, city population 150,000. Apply Mrs. Wanda Reed, Northwest Texas Hospital, Amarillo, Texas.

DIRECTOR PSYCHIATRIC NURSING—In a new 100-bed psychiatric teaching, training and research center; superior teaching facilities; responsible for the nursing education of affiliate students and the organization and administration of the nursing service; university faculty appointment; salary open depending upon preparation and experience. Write Cecil Wittson, M.D., Director of Nebraska Psychiatric Institute, University of Nebraska College of Medicine, 602 South 44th Avenue, Omaha 5, Nebraska.

INSTRUCTOR—Obstetric nursing; in a fully accredited school of nursing; 170 students, 350-bed hospital in large metropolitan city with educational and cultural advantages; college affiliation; housing available; liberal personnel policies; salary open. Apply MO 180, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

INSTRUCTORS—Clinical; for operating room technique and in medical and surgical nursing, day, evening and night shifts; integrated program; affiliated with Drake University; 200 students in school; 400-bed, fully approved, non-profit hospital; minimum qualifications: B.S. degree, preferably in nursing education; salary open, 40 hour work week; 20 working days vacation; sick benefits; position open immediately. Apply Director of Nursing, Iowa Methodist Hospital, Des Moines, Iowa.

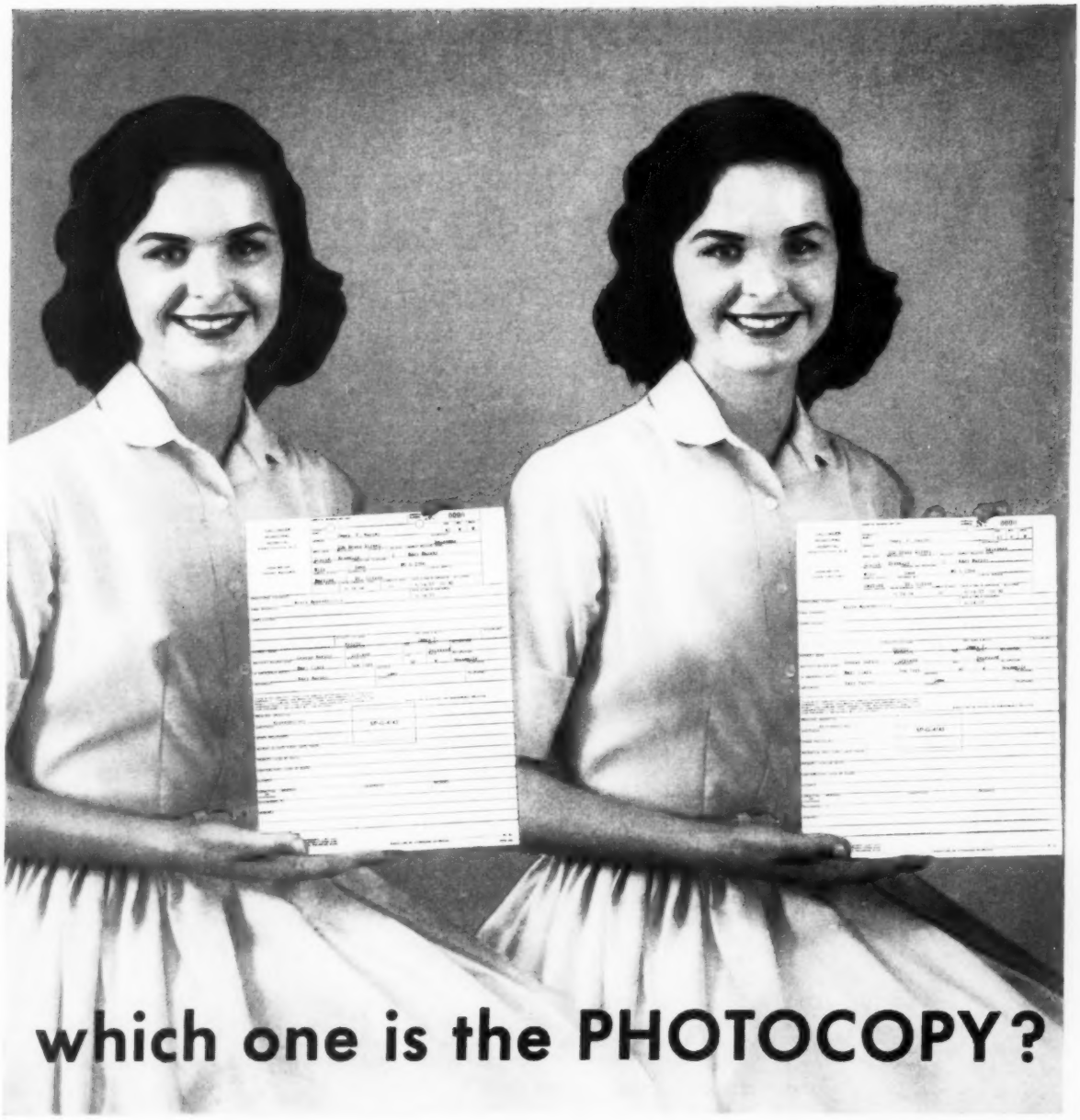
INSTRUCTORS—Psychiatric clinical nursing. (3) progressive State hospital with affiliate nursing program; starting salary dependent upon academic qualifications, experience and personal qualifications; starting range from $3120-$4300 plus self maintenance; liberal sick time, holidays, paid vacation. Write to Dr. J. O. Cromwell, Superintendent, Mental Health Institute, Independence, Iowa.

INSTRUCTOR—Psychiatric nursing; progressive State hospital with affiliate nursing program; starting salary dependent upon academic qualifications, experience and personal qualifications; starting range from $4300 to $6000 plus self maintenance; liberal sick time, holidays, paid vacation. Write to Dr. J. O. Cromwell, Superintendent, Mental Health Institute, Independence, Iowa.

INSTRUCTOR—Clinical-psychiatric nursing; for our affiliate psychiatric school of nursing, BS degree in Nursing Education, post graduate preparation in psychiatric nursing, ability to supervise and to teach nurses and aides in clinical area; salary open; 40 hour week with excellent benefits. Write to Personnel Supervisor, State Hospital, Jamestown, North Dakota.

INSTRUCTOR—Clinical; operating room; NLN accredited diploma school; assist operating room supervisor and teach formal and clinical classes for professional students; salary commensurate with qualifications; 40 hour week. Apply Mrs. Wanda Reed, Northwest Texas Hospital, Box 1110, Amarillo, Texas.

(Continued on page 188)



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POSITIONS OPEN

LIBRARIAN—Registered medical records; to assume charge of record room in a 220-bed hospital near Boston; forty hour week; excellent fringe benefits; salary open. Apply MO 208, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

LIBRARIAN—Medical records; registered or eligible for registration, to head the department in a 500-bed tuberculosis hospital; liberal holidays, vacations, sick leave benefits and pension plan. Apply Medical Director, P. O. Box 1411, Lantana, Florida.

LIBRARIAN—Medical record; with demonstrated successful experience to serve as chief of department for 400-bed non-profit accredited teaching hospital which includes 115-bed pediatric unit; desire person capable of taking over current department with able assistants and with ability to supervise personnel and organize paper work flow and to adjust departmental work loads. Apply Personnel Director, Iowa Methodist Hospital, Des Moines, Iowa—friendly capital city of Iowa which includes campus of Drake University.

LIBRARIAN—Medical record; registered to assume charge of record room; 135-bed general hospital; 40 hours; salary open. Contact Miss G. A. Cooper, Woman's Hospital, Cleveland 6, Ohio.

MISCELLANEOUS — Registered Laboratory Technician and Nurses for immediate employment; small hospital near Yellowstone Park and Grand Tetons; all shifts, good salary, 40 hour week, meals, laundry, sick leave, holidays and vacation. Apply St. Anthony General Hospital, 126 South Bridge, St. Anthony, Idaho.

MISCELLANEOUS — Supervisor and Head Nurse; Evening duty; 211-bed modern children's hospital offering 13 weeks program for basic nursing students from diploma schools; at least 5 years experience required for supervisor; at least 3 years experience required for head nurse; starting salary dependent upon qualifications; liberal vacation and sick leave policy; 40 hour week. Write Director of Nursing, The Children's Hospital, Cincinnati 29, Ohio.

MISCELLANEOUS — SUPERINTENDENT — Duties to commence November 1, 1957, for 35-bed hospital; complete staff at present time. Apply stating references, age, experience and salary expected. FLOOR SUPERVISOR—P.G. in obstetrics preferred; salary $220 gross. Apply Mrs. I. Garrow, Sec. Treas., County of Bruce General Hospital, Walkerton, Ontario.

NURSE—Operating room; for modern air-conditioned, two room suite, in 52-bed general hospital; 12 days sick leave, 2 weeks vacation annually, paid holidays, annual bonus, 40-hour week; salary open. Apply Director of Nurses, Parkview Hospital, 1920 Parkwood Avenue, Toledo 2, Ohio.

(Continued on page 190)

NURSES—Enjoy Florida living at its best in beautiful Miami; we invite you to join our staff in this progressive 1000-bed medical center affiliated with the University of Miami; liberal personnel policies, 40 hour week, free uniform laundry, evening and night differential; starting: R.N. $270, L.P.N. $222. Write to Director of Nurses, Jackson Memorial Hospital, Miami, Florida.

NURSES—Operating room and staff; for 227-bed pediatric hospital in sunny California; salary $315 per month with differential for operating room and evening and night duty; 5 day, 40 hour week; liberal personnel policies including vacation, sick time and retirement. Apply Director of Nursing, Childrens Hospital Society, 4614 Sunset Blvd., Los Angeles 27, California.

NURSE—Operating room; experienced; 200-bed tuberculosis hospital; maintenance provided. Send complete resume to Mrs. Huegel, Eagleville Sanatorium, Box 45, Eagleville, Pennsylvania.

NURSES — Psychiatric; for supervising psychiatric buildings and attendants; mature experienced; $3,000 per year, board, room and laundry available at $480 per year; social security and pension. Send full information to Director of Nurses, Brattleboro Retreat, Brattleboro, Vermont.

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POSITIONS OPEN

NURSE — Registered; interested in teaching practical nursing; opportunities to develop own program; school not approved at present; desire individual capable of developing program which will meet State approval; small town located in southeast Pennsylvania. Apply MO 144, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

NURSES—Registered; for modern psychiatric hospital in Greens Farms, Connecticut; 1 hour from New York; Hall-Brooke nurses have 8-hour duty, optional 5 or 6 days week, nicely furnished private rooms; excellent salary, 7 paid holidays annually, or equivalent; sick leave; vacation, minimum 2 weeks, maximum 4 weeks dependent on length of service; profit-sharing plan; psychiatric experience not necessary; registered or eligible in State of Connecticut. Apply Mary R. Walsh, R.N., Directress of Nursing, Hall-Brooke, Box 31, Greens Farms, Connecticut. Tel. Westport — Capital 7-5105.

NURSES—Graduate staff; for full and part time positions; 147-bed hospital with school of nursing, situated 100 miles from New York; beginning salary ranging from $265-$270 to $300, evening duty bonus $20, night duty bonus $30, operating room call bonus $15, paid vacation and sick leave, full maintenance available. Apply Director of Nursing, Southampton Hospital, Southampton, New York.

NURSES—Registered; all shifts, for general staff duty; O.R., O.B.; $250-$270; 150-bed modern well equipped hospital; for further information write Personnel Office, Holy Cross Hospital, Fort Lauderdale, Florida.

NURSES — Registered; immediate openings; starting salary $240 month with opportunity for advancement; room, board and laundry annual vacation, liberal sick leave, 40 hour, 5 day week. Apply Personnel Office, Mental Health Institute, Independence, Iowa.

NURSE—Registered; for thirty-eight bed general hospital; salary $270.00 per month with periodic increases; excellent personnel policies. For further information apply Superintendent of Nurses, Red Wing City Hospital, Red Wing, Minnesota.

NURSES — Registered; psychiatric hospital; liberal personnel policies; 40-hour week, attractive residence; positions available on all shifts; differential salary for evening and night service. Inquire Director of Nurses, Essex County Overbrook Hospital, Cedar Grove, New Jersey.

NURSES — Registered; New Jersey license; charge duty; excellent salary, 5 day week; 7:30-3:30 and 3:30-11:30; attractive living quarters if desired; modern home for aged. Apply Hebrew Home, 198 Stevens Avenue, Jersey City 5, New Jersey.

NURSES—Registered general duty; for 50-bed general hospital; good working and living conditions; ideal climate; starting salary $280 per month. Apply to W. R. Coe Memorial Hospital, Cody, Wyoming.

(Continued on page 192)

NURSING—Staff; annually $3000 to $3360 plus two meals daily and uniform laundry, six paid holidays, liberal sick leave and vacation. Apply Director of Nursing, Episcopal Eye, Ear and Throat Hospital, 1147 15th St., N.W., Washington 5, D.C.

NURSES—Staff; Portland, Oregon is a fine place to live; we think the University of Oregon Medical School Hospital is a fine place to work; openings for staff nurses in pediatric, medical surgical, operating room and psychiatric units; starting salary for those with six months' or more experience — $310.00 per month; liberal personnel policies; opportunities to take classes in graduate nurse programs on campus at reduced tuition rates. Write for further information to Director of Nursing Service, University of Oregon Medical School Hospital, Portland 1, Oregon.

SUPERVISOR—Housekeeping; salary $5287 to $5957 per year; this is a new executive housekeeping position in a 450-bed general hospital located 17 miles from downtown Detroit; duties will include internal administration of the housekeeping department and supervision of cleaning and decorating in the hospital; experience on a responsible supervisory level in the housekeeping department of a large hospital or hotel is required. For further information write to Dr. Douglas McDowell, Wayne County General Hospital and Infirmary, Eloise, Mich.

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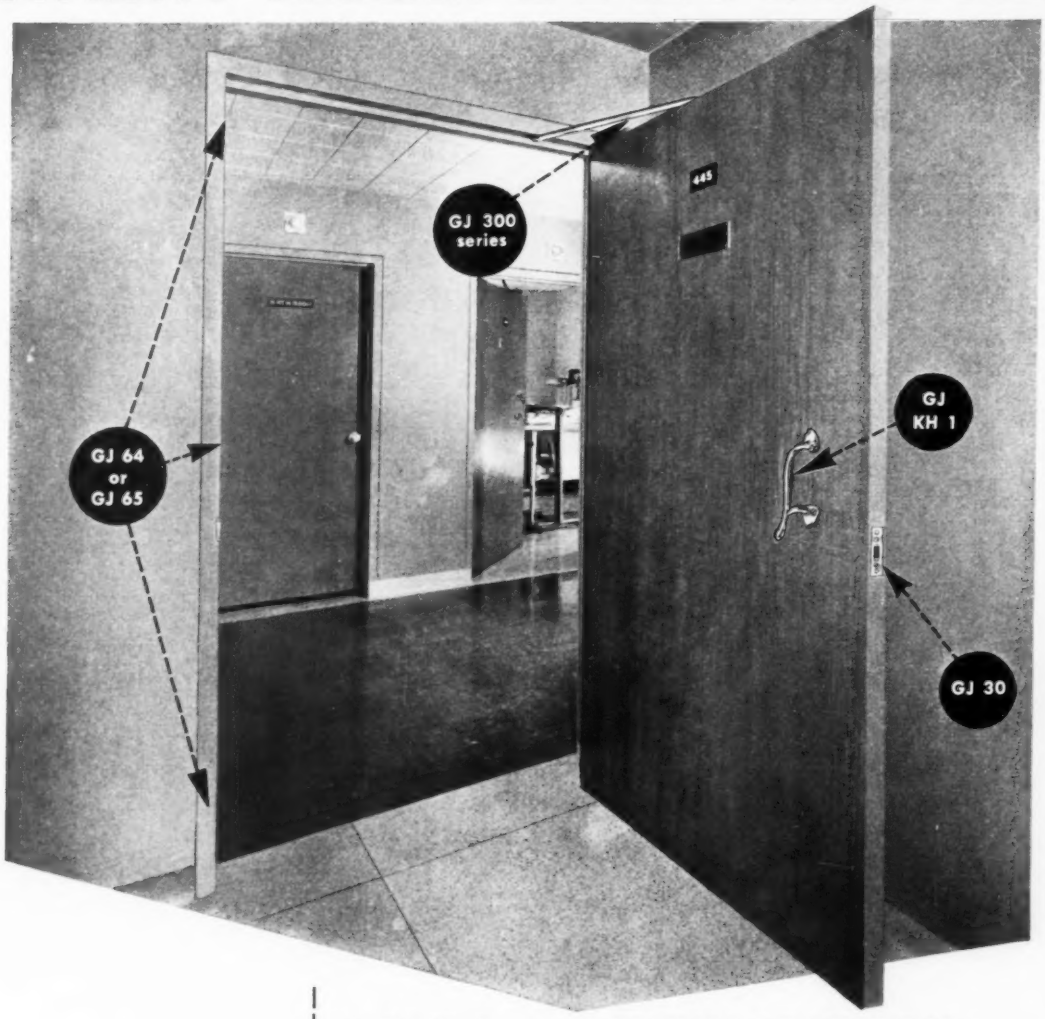

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"GJ KH 1 COMBINATION HAND AND ARM PULLS to be mounted back to back as a pair." (Convenient for opening door from either side with sterile hands or when carrying loaded trays.)

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SUPERVISOR—Assistant; in operating rooms; 300-bed hospital; adequate, modern equipment; 40 hour week; 20 paid days vacation, cash salary; liberal personnel policies; preparation and experience desired; salary open. Apply, Director of Nursing, Mercer Hospital, Trenton, New Jersey.

SUPERVISOR—Operating room; NLN accredited diploma school; 230-bed general hospital; average 20 operations daily; 40 hour week, salary commensurate with qualifications. Apply Mrs. Wanda Reed, Northwest Texas Hospital, Box 1110, Amarillo, Texas.

TECHNOLOGIST—Laboratory; 250-bed hospital; salary open. Apply MO 171, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

TECHNOLOGIST — Experienced registered chief medical laboratory technician for supervision of laboratory work and student training in modern, well equipped 300-bed hospital; salary dependent on qualifications. Apply Pathologist, St. Luke's Methodist Hospital, Cedar Rapids, Iowa.

TECHNICIANS—Laboratory; two wanted for 58-bed hospital by October first; top salary, three weeks vacation, sick leave and holiday time with pay. Write for full details state age and experience. Mt. Desert Island Hospital, Bar Harbor, Maine.

TECHNOLOGISTS—Medical registered 160-bed general hospital, college town, 20 miles west of Milwaukee, major expansion program including new department of laboratory medicine to be started in spring of 1957; affiliation with Carroll College for training of medical technologists now in development stage; full time pathologist. Apply Personnel Department, Waukesha Memorial Hospital, 725 American Avenue, Waukesha, Wisconsin.

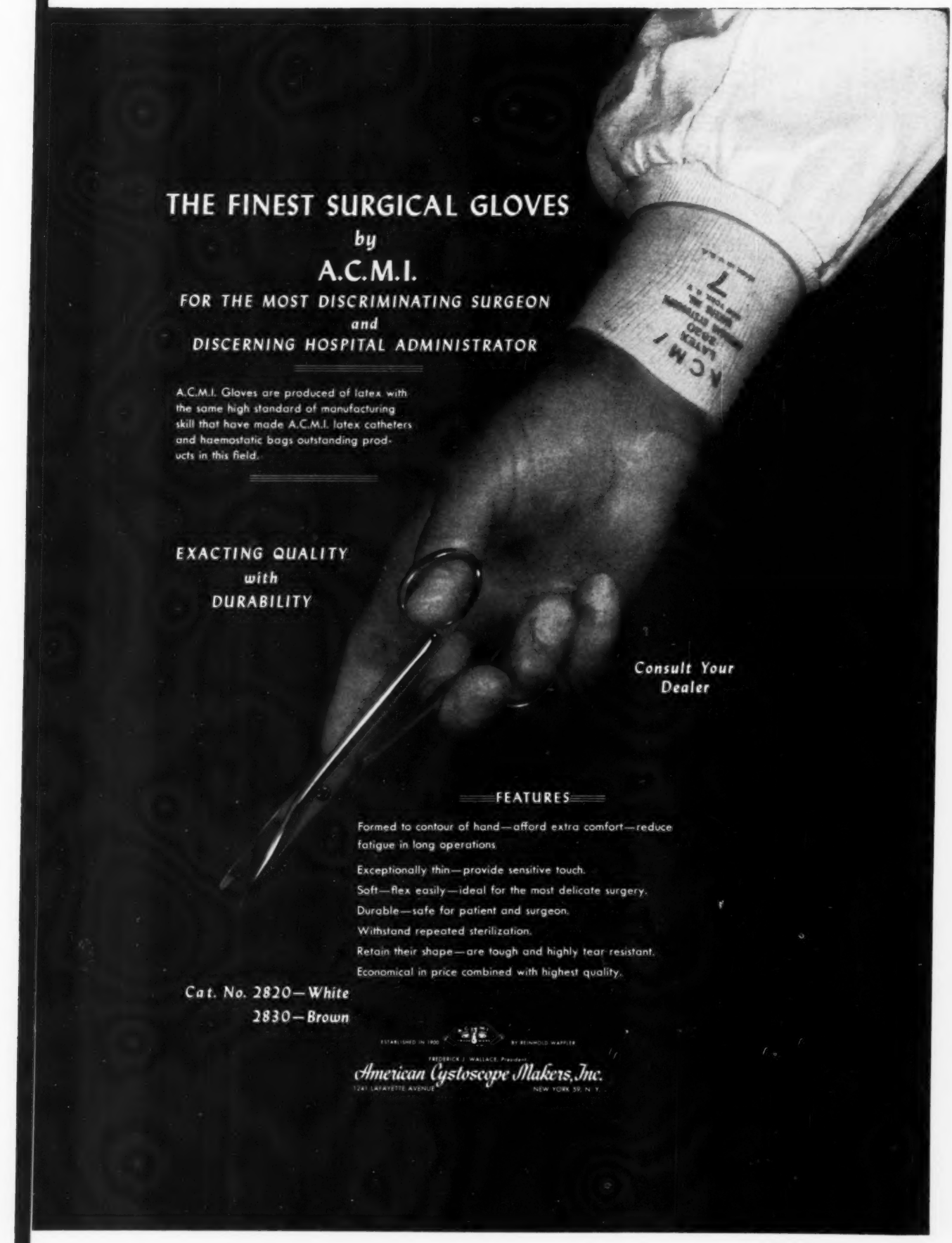
ADMINISTRATION — (a) Non-medical or medical; newly created post; fully approved 600-bed voluntary general teaching hospital; cooperative board; university city; midwest; prefer Member ACHA. (b) New 300-bed general hospital to be constructed; will appoint director now; requires Member ACHA, West. (c) Medical; JACH voluntary general; foremost teaching hospital in area; large city; east. (d) 200-bed, fully approved general; requires one who is affiliated with ACHA;

(Continued on page 194)

WOODWARD—*Continued*

university city; midwest. (e) FACHA capable taking over full range, both medical and non-medical; accredited 200-bed general; east. (f) New post; 150-bed general; California. (g) General voluntary JCAH hospital, 130-beds adding 70-beds now; good staff; cooperative board; college town, 30,000 not far large city; midwest. (h) Fully approved 125-bed voluntary general hospital recently opened; university city; southwest. (i) General hospital fairly large size in Detroit vicinity; to $15,000; requires 5 years experience. (j) New 100-bed voluntary hospital; resort town, 15,000; southeast. (k) 100-bed voluntary general near Adirondacks; town 10,000, northeast. (l) 100-bed voluntary general, FACH not far from Chicago. (m) 80-bed JCAH general in scenic Pacific Northwest. (n) Direct 60-bed hospital and serve as consultant in opening about 5 others; direct hospitals as opened, appoint successor and move on; about $15,000; west coast; requires ACHA.

ASSISTANT ADMINISTRATORS—(o) 500-bed hospital operated under American auspices; interesting city outside United States. (p) University hospital; requires one with minimum 3 years hospital administrative experience; east. (q) Report directly to FACHA; will supervise minor departments; university town; northeast. (r) General hospital expanding to 200-beds; southeast; with degree and several years experience; large general hospital; California. (s) Fully approved 400-bed voluntary general; requires one fully ex-



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WOODWARD—*Continued*

perienced all phases hospital relations; large city on Lake Erie. (t) One able reorganize front office having good accounting background; 175-bed fully approved general voluntary teaching hospital; vicinity Boston; $7000. (u) Business Officer; fully approved 700-bed general voluntary teaching hospital; newly created post; will be substantial for exceptional man; university city; midwest. (v) Business Officer; 100-bed voluntary general hospital; Massachusetts.

The Medical Bureau

M. BURNICE LARSON—DIRECTOR

Telephone DElaware 7-1050

900 NORTH MICHIGAN AVENUE CHICAGO

ADMINISTRATORS—(a) Medical; 400-bed general hospital affiliated medical school; university city, east. (b) Medical director; new 85-bed hospital; active outpatient clinic, 500 patients monthly; California; $15,000. (c) Administrator; new general hospital, 50-beds; California. (d) New 75-bed general hospital; Florida. (e) To succeed administrator retiring after 22-year tenure; hospital 250-beds; university city, west. (f) Executive secretary; medical society; university city, west. (g) Business managers; 8 man group Master's in Hospital Administration, administrative experience required; town 50,000 near Chicago. (h) Assistant administrator; preferably one with accounting background and experience which would qualify him for administrative advancement; 175-bed general hospital; building program; medical center, east. (i) Assistant in charge of emergency room and outpatient services; 450-bed general hospital; expansion program; midwest. (j) Assistant; 200-bed general hospital, principal teaching facility of university medical school; east. MH10-1.

ANESTHETISTS—(a) General 250-bed hospital; department directed by medical anesthesiologist; university city, south; $8000. (b) Excellent opportunity, 100-bed general hospital; attractive resort town, Arizona. (c) Staff, 170-bed general hospital near Yale university; attractive business arrangements. (d) General 100-bed hospital on Lake Michigan, resort town, Wisconsin; substantial salary. MH10-2

DIETITIANS—(a) Chief; 250-bed hospital; 60 dietary employes; opportunity reorganize; $6000 up; midwest. (b) Nutritionist; faculty position, collegiate nursing program; New York City area; $520 month. MH10-3

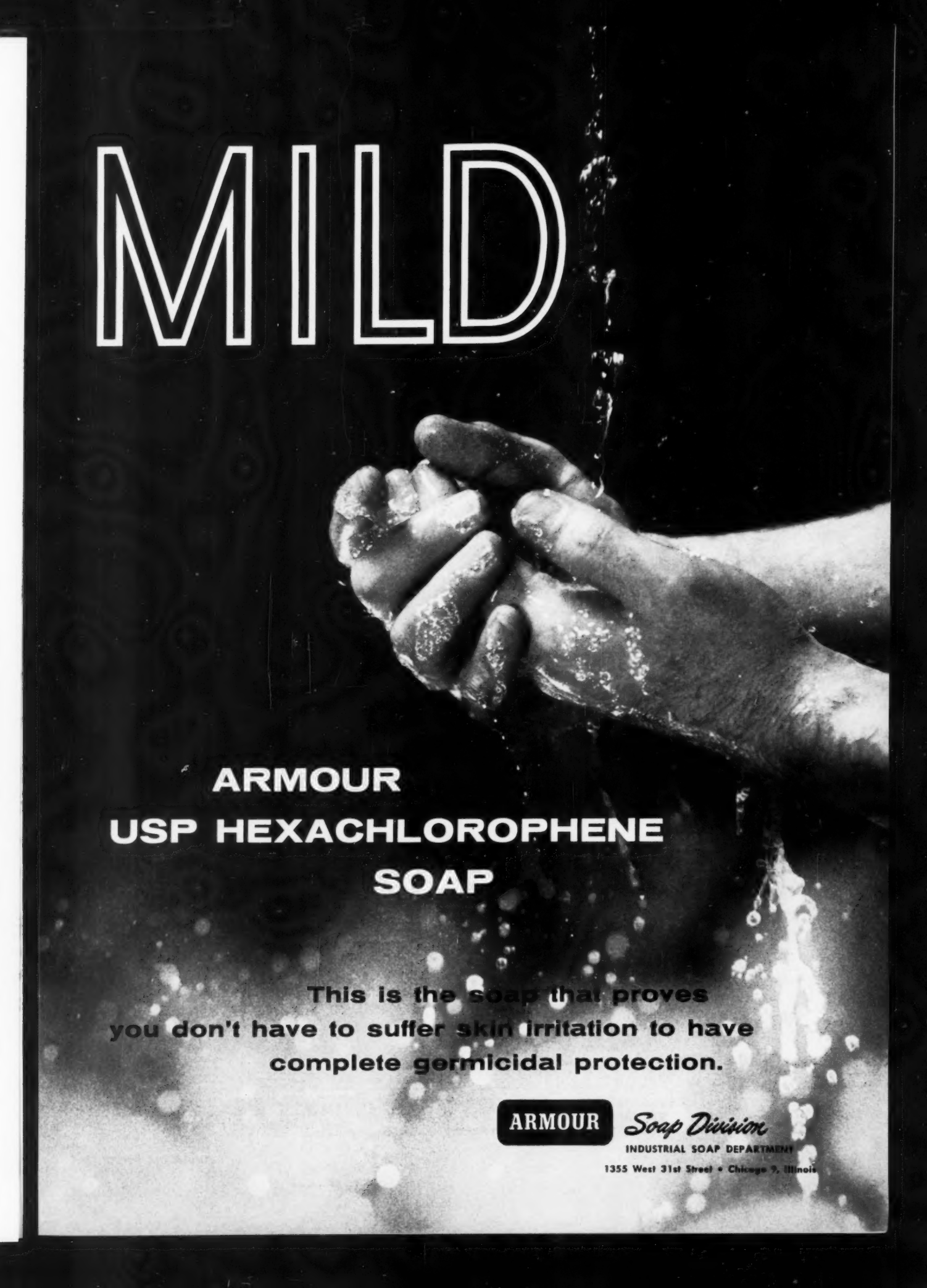
MEDICAL BUREAU—*Continued*

DIRECTORS OF NURSING—(a) Director of nurses; responsible school, service; college affiliation, 400-beds; commuting distance, New York City; $10,000. (b) Director nursing service; 300-bed hospital increasing to 450 near future; opportunity exercise initiative; progressive administration; excellent financial possibilities; west coast. (c) Director service, education; 350-bed hospital, 120 students; outstanding opportunity, university city, New York state near Canada. (d) Director nurses; 75-bed well equipped hospital, small friendly college town; congenial atmosphere; attractive salary; Ohio. MH10-4

EXECUTIVE PERSONNEL—(a) Chief accountant; new 250-bed general hospital; near Chicago. (b) Business manager; preferably one with accounting background; 450-bed general hospital; city 145,000 near Philadelphia. (c) Chief engineer; 400-bed general hospital; preferably degree in engineering but not mandatory; medical school city, midwest. (d) Comptroller; 300-bed general hospital; university city, southwest. (e) Food director, 900-bed teaching hospital; university city, New York; top salary. (f) Personnel director; 600-bed hospital affiliated research institution; 1200 employes; east. MH10-5

EXECUTIVE HOUSEKEEPERS—(a) Large hospital; leading resort area, Florida; top salary. (b) 700-bed hospital with expansion program to 900; 115 in department; $5500 up; midwest. MH10-6

(Continued on page 196)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POSITIONS OPEN

MEDICAL BUREAU—*Continued*

FACULTY POSTS—(a) Coordinator; practical nurse adult education program; public school system; $6500; also instructor, $6000, New York. (b) Associate director nursing education; well renowned 350-bed hospital; exceptional facilities; 200 students; university affiliation; suburb, leading midwest city; $7200 up. (c) Assistant professor nursing; conduct university work shops, institute; teach ward administration; $6000, travel expenses; midwest. (d) Operating room clinical instructor; teach students, train operating room technicians; excellent opportunity; Greater Manhattan. (e) Instructor; foreign assignment, major industrial company; $695 month. MH10-7

MEDICAL RECORD LIBRARIANS — (a) Chief; supervise work of four city hospitals as consultant; excellent experience and financial opportunity; leading industrial city, midwest. (b) Recent graduate will be considered chief, 160-bed hospital, vicinity Cape Cod; outstanding facilities; supervise three; cooperative medical records committee. MH10-8

SUPERVISORS—(a) Foreign assignment; responsible central supply, operating room; United States major industrial company hospital; $850 month. (b) Operating room; good administrative ability required for busy surgery; large general hospital commuting distance New York City; to $7000. (c) Supervise-manage convalescent home, Chicago lake front; excellent facilities; living accommodations available. (d) Emergency room; 175-bed general hospital; exclusive Florida resort; good salary. MH10-9

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MEDICAL DIRECTOR—(a) Large psychiatric hospital; New England State; must be board certified; $14,000 plus full maintenance. (b) Assistant Superintendent for large New England hospital for mentally retarded children; salary $12,000 plus full maintenance; psychiatric experience required. (c) Educational director for large southern hospital; salary open.

ADMINISTRATORS — (a) 400-bed western state hospital; Degree in Hospital Administration plus seven years experience required; large city; salary open. (b) 300-bed hospital; metropolitan area; Degree plus 8 years experience required; salary open. (c) 50-bed hospital; salary $8,000; midwest. (d) 200-bed, New England hospital; salary $8,500 to begin. (e) State hospital; midwest; salary $10,000 per annum; Degree in Hospital Administration required.

ASSISTANT ADMINISTRATORS—(a) Large midwest hospital; background in personnel and public relations required; 400-bed hospital; salary $8,500. (b) Assistant administrator; large New England hospital; background in accounting required; salary open. (c) Assistant administrator; large State hospital; $7,000 per annum to begin.

BUSINESS MANAGERS—(a) 300-bed Catholic hospital; Ohio; salary open. (b) 250-bed hospital; midwest state; salary open. (c) 100-bed hospital; Ohio. (d) 50-bed hospital; New England; $8,500.

CREDIT MANAGERS—(a) 200-bed Ohio hospital; salary open. (b) 300-bed hospital; south; salary open.

FOOD SERVICE MANAGERS—(a) Large state hospital; Ohio; salary open. (b) Large teaching hospital; south; salary open.

(Continued on page 198)

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POSITIONS OPEN

MEDICAL EMPLOYMENT—*Continued*

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DIETITIANS—(a) Administrative; large 400-bed hospital; MS Degree plus experience required; salary open; commission fee paid by hospital. (b) Administrative dietitian; Degree plus experience required; 250-bed southwest hospital; salary open, commission fee paid. (c) Therapeutic dietitian; 200-bed hospital; commission fee paid.

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ADMINISTRATOR—(a) 175-bed eastern hospital; business management training. (b) 190-bed hospital, private, Pennsylvania. (c) 52-bed hospital, Iowa.

INTERSTATE—*Continued*

ASSISTANT ADMINISTRATOR—(a) 200-bed teaching hospital. (b) 120-bed hospital, Ohio. (c) 140-bed New York hospital. (d) R.N. 40-bed western hospital.

COMPTROLLER—(a) 125-bed hospital, east. (b) 175-bed Ohio hospital; expansion program.

PERSONNEL DIRECTOR—240-bed midwest.

DIRECTOR OF NURSING—(a) 325-hospital, east, $8000. (b) 300-bed hospital, south. (c) 200-bed hospital. (d) Directors, nursing service.

TECHNICIANS—(a) Laboratory, $400. (b) X-ray, Ohio, mid-west. (c) Pharmacists. (d) Anesthetists, $6,000. (e) Medical Record Librarians.

EXECUTIVE HOUSEKEEPER—(a) 225-bed hospital, large Michigan city. (b) 300-bed southern hospital. (c) 240-bed hospital, mid-west. (d) 325-bed hospital, New Jersey. (e) 2700-bed MN hospital.

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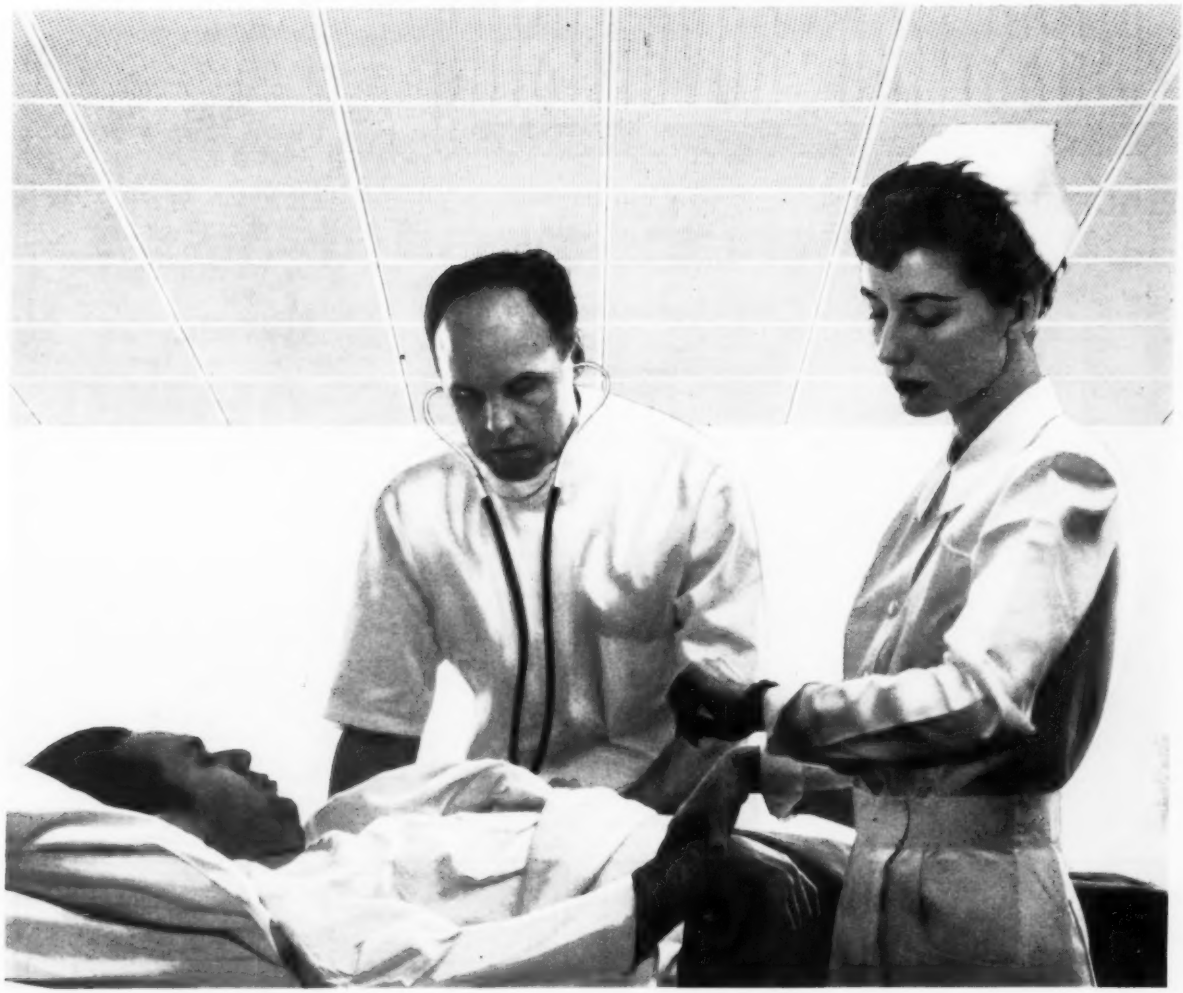
MEDICAL BIOSTATISTICIAN—Professional activity study of a professional and hospital commission; duties: initiate plans, outline procedures, carry out analysis, prepare reports; act as consultant on statistical aspects of undertakings for other staff members; represent commission at professional meetings, etc.; salary to $12,000.

SHAY—*Continued*

DIRECTORS OF NURSING—(a) California; 200-bed hospital—adding 90 beds; teaching hospital; $7500. (b) Large psychiatric hospital; B.S. degree. 5 years administrative experience; $7000. (c) Middle west; 100-bed hospital; degree not required $6000. (d) South; 245-bed hospital; fully approved; 186 employes in department; city of 85,000; $6000. (e) East; 200-bed hospital near Boston; degree not necessary; $6000. (f) Middle west; 190-bed hospital in resort area—easily accessible to Chicago; $6500. (g) Middle west; 225-bed hospital in city of 50,000; very progressive nursing service; to $7500 plus complete maintenance. (h) East; 500-bed hospital affiliated with medical college; $7500 to $10,000.

PHARMACISTS—(a) California; 60-bed hospital near San Francisco; $6300. (b) California; 200-bed hospital; 3 pharmacists; $6900. (c) Chief; middle west; 70-bed general hospital; do all purchasing; $5400. (d) East; 350-bed hospital; will be assistant to Chief; 40 hour week; $5400-$6000. (e) Chief; Pacific Northwest; 75-bed hospital—supervise buying and drugs; $5700.

(Continued on page 200)



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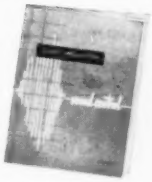

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We do have many interesting openings for Administrators, Physicians, Anesthetists, Directors of Nurses, Dietitians, Medical Technicians, Therapists, and other supervisory personnel.

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Agency

(Continued on page 202)

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Dorothea Bowlby, Director

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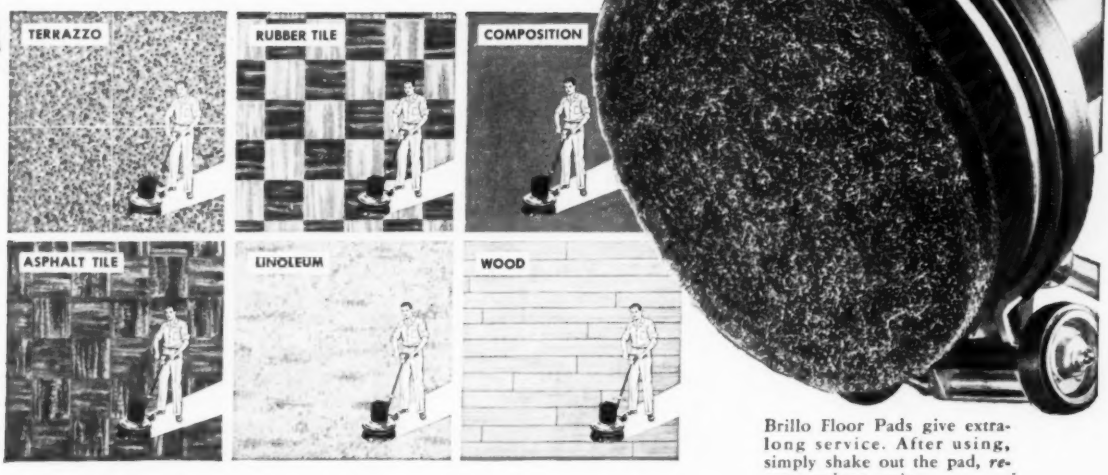

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(Continued on page 204)

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The CHICAGO LYING-IN HOSPITAL AND DISPENSARY of the University of Chicago offers a six-months course in OBSTETRIC NURSING to qualified graduate nurses. The course includes all phases of maternity nursing. The student may elect experience in one special area for two months of the course. Modern, attractively appointed kitchenette apartments are provided. Adequate allowance is made for food and laundry. For further information, write to the Director of Nursing, 5841 Maryland Avenue, Chicago 37, Illinois.

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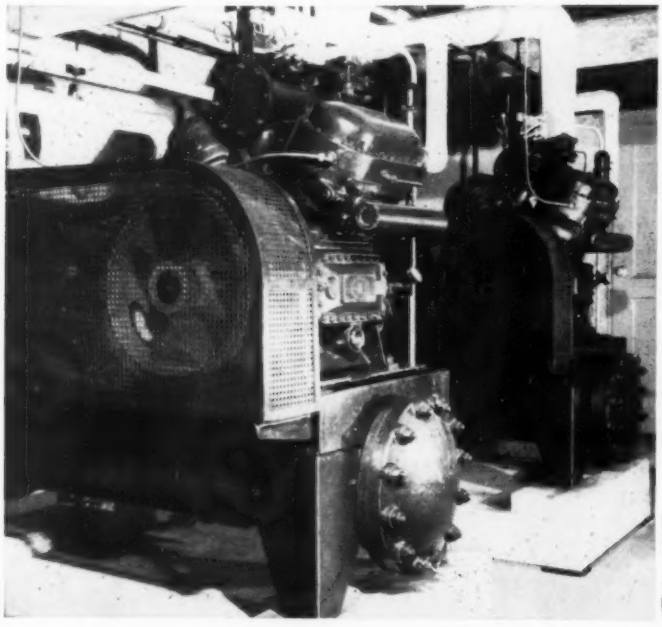

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NOW...for perfect harmony with clean lined modern design...

NORTON "INADOR"

The modern concealed door closer with built-in ruggedness

(A) (B)

Available with (A) regular arm or (B) holder arm . . . 4 sizes to meet all requirements

now available!

SteriSharps®

the first sterile, stainless-steel surgical blade

new SteriSharps valuable aid to surgeons and nurses...saves time, eliminates blade waste

The new SteriSharps surgical blade is made of stainless steel. It has the sharpest, most uniform, most durable cutting edge available. Comes to you ultrasonically cleaned and heat-sterilized for asepsis. Saves time, simplifies technic.

Surgeons can depend on *consistent sharpness* with SteriSharps. Electronic testing by the ASR Sharpometer® guarantees uniform sharpness.

SteriSharps offer important economies, too. Only blades actually needed are used. They're unaffected by autoclaving, dry heat, solutions. Sealed packets can be re-autoclaved, stored indefinitely. For details, write: ASR Hospital Division, Dept. MH, 380 Madison Ave., N. Y. 17, N. Y.

Only SteriSharps offer all these advantages . . .

- Sharpest, most durable cutting edge
- Consistent sharpness in every blade
- SteriSharps will not corrode
- Can be re-autoclaved, stored in packs
- Sterile SteriSharps eliminate jars, racks and irritating solutions

Blade Dispenser available. Your supplier has SteriSharps surgical blades in every design. Stainless-steel dispenser shown above is yours free with every five gross.

A·S·R precision products

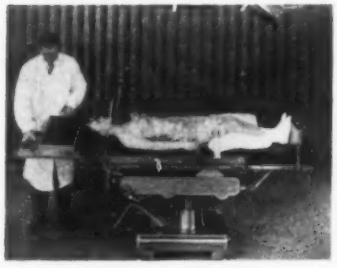
SteriSharps . . . the first sterile, stainless-steel surgical blade

WHAT'S NEW FOR HOSPITALS

TO HELP YOU get more information quickly on the new products described in this section, we have provided the convenient Readers Service Form opposite page 248. Check the numbers on the card which correspond with the numbers at the close of each descriptive item in which you are interested. The MODERN HOSPITAL will send your requests to the manufacturers. If you wish other product information, just write us and we shall make every effort to supply it.

Cassette Tunnel Pad Permits Operative Radiography

Precise radiography during operative procedures is now possible with the new Cassette Tunnel Mattress Pad. There is no interference with the surgical team since loading, positioning and unloading are accomplished from outside the sterile field. The No. 1835 Pad is used on the operating table when the patient is brought in if radiography is anticipated. An integral part of the table, the pad responds to height, tilt and Trendelenburg. The cassette can be placed in any desired position through a special spring lock on the sliding tray. **American Sterilizer Co., Erie, Pa.**



For more details circle #647 on mailing card.

Simple Accurate Method for Hemoglobin Tests

Simple, accurate calibration in hemoglobin determinations is possible with the new Hycel Cyanmethemoglobin Reagents. To prepare a calibration it is only necessary to run a blank and four dilutions of the standard, with the standard as an accuracy control. Instructions for use and a detailed manual, including theory and history of the technic, are furnished with each bottle of standard. **American Hospital Supply Corp., Scientific Products Div., Evanston, Ill.**

For more details circle #648 on mailing card.

Mayo Tray Attachment Fits All I.V. Stands

Designed to fit practically all I.V. Standards, the new Lumex #305 Mayo Tray Attachment is made to accommodate the regular stainless steel instrument tray. The bracket is made entirely of cadmium plated steel and is available with or without the stainless steel tray. **General Medical Equipment Corp., Div. of Lumex, Inc., Valley Stream, N.Y.**

For more details circle #649 on mailing card.

Important Development in Laboratory Glassware

A new source of hard borosilicate glass for laboratory and scientific glassware is now available to the hospital, surgical and laboratory fields. Given the trade name of Kimax, the new glass was introduced by Glasco Products Company. It is the result of years of research and development by Kimble Glass Company, manufacturer of scientific glassware for over forty years, and Owens-Illinois Glass Company. Kimax is reported to have passed every possible test for a tough, hard glass meeting the highest standards of resistance to thermal shock, impact and chemical reaction. It is completely interworkable with other hard glass apparatus having the same linear coefficient of expansion.

Known technically as KG-33, the new hard borosilicate glass will eventually be used in all appropriate laboratory glassware items, according to the announcement. Now available in Kimax are approximately 370 different laboratory glassware items, each in a wide range of sizes and capacities, both graduated and ungraduated. With the introduction of Kimax, users of laboratory glassware will be able to fill their needs from one source, including items ranging from simple test tubes to complex units in a wide range of shapes, sizes and construction. **Glasco Products Co., 111 N. Canal St., Chicago 6.**

For more details circle #650 on mailing card.

Direct Writing Cardiograph Is Lightweight

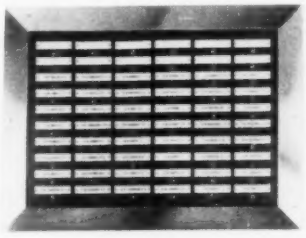
Full scale performance is available in the new Cardi-All Direct Writing Electrocardiograph. The unit features simplicity of operation and rugged performance. The manufacturer describes the standardization cell as being lifetime guaranteed. The Cardi-All is modern in appearance, light in weight and easily portable. **Beck-Lee Corp., 630 W. Jackson Blvd., Chicago 6.**

For more details circle #651 on mailing card.

(Continued on page 212)

Doctors' Registry Board Has Plexiglas Name Plates

Plexiglas name plates for clear visibility is one of the features of the new Doctors' Registry Board introduced recently. Bulbs and name plates are easily changed and delivery of new name plates take only five days. The Toole Registry Board is available for remote control and in multiple and special types. All boards have a six-volt electrically controlled panel and transformer with Underwriters Laboratories approval. The anodized aluminum panels are available in black or silver finish.



The new boards are economically priced, available for varying numbers of names, and are offered for flush mounting in new construction and surface mounting in shadow box frame for existing hospitals. **Toole Engraving Co., Electronics Div., 5112 Melrose Ave., Los Angeles 38, Calif.**

For more details circle #652 on mailing card.

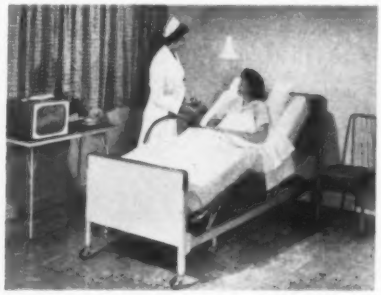
Band-Aid Clear Tape Is Transparent Adhesive

Virtually invisible in use, the new Band-Aid Clear Tape is a transparent adhesive bandage. It is designed to blend with the skin to eliminate the appearance of a bandage. Its dull surface does not reflect light and the natural skin color shows through. The new tape is strong, yet light and flexible, conforming and adhering to natural contours without binding or pulling. It is waterproof and has the same effective sticking quality as other Johnson & Johnson adhesive products. **Johnson & Johnson, New Brunswick, N.J.**

For more details circle #653 on mailing card.

Sim-Matic Vari-Hite Beds Are Completely Motorized

Patients who are permitted changes of position can now operate bed height



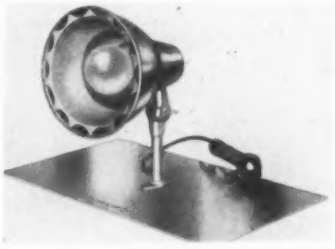
and spring adjustments by a control switch held in the hand. Known as the Sim-Matic, the new completely motorized Vari-Hite bed provides greater comfort for the recuperating patient while freeing nurses and aides from the chore of bed adjustment. Clearly marked, it is easy for the patient to operate the control switch as he holds it. Adjustments from the slightest to full change of position or height are quickly made by the patient. In cases where change of position is not permitted, cut-out switches inactivate either or both sections of the spring. Manual crank operation is provided in case of power failure.

The quiet, induction type motor is fully enclosed with all movements controlled by limit switches to cut off current if it is not turned off. Sim-Matic Beds are available in all Simmons standard colors or with Textolite panels on head and foot ends. **Simmons Company, Merchandise Mart, Chicago 54.**

For more details circle #654 on mailing card.

Perineal Lamp Has Double Reflector

The "Coolshade" principle of double reflector is employed in the new Continental Perineal Therapy Lamp. Ample air space is built-in as insulation so that



the lamp stays cool for the comfort and safety of the patient. It is so designed that it cannot tip and the ratchet-type shade adjusts in three directions. The lamp is economically-priced and uses a 25-watt bulb. **Continental Hospital Industries, Inc., 18624 Detroit Ave., Cleveland 7, Ohio.**

For more details circle #655 on mailing card.

(Continued on page 216)

"I guarantee Thurmaduke Waterless Food Warmers will preserve the appearance and flavor of hot food"

says M. P. Duke, President, Duke Manufacturing Co.

Your success depends on the food you serve. Dried-out, overheated, discolored food hurts your reputation and your chances for a profitable volume. You can protect your reputation and your profit with a modern Thurmaduke Waterless Food Warmer.

Thurmaduke guarantees perfect food storage. Thurmaduke has more efficient Selective Heat Control for each section than any other food warmer made. Foods like this roast turkey, which requires a temperature of 145°, mashed potatoes, 125°, or thin gravy and soups, which require a temperature of 190°, can be stored at the exact temperature each requires. Each section is fully insulated on all sides and bottom to prevent heat passage between sections. This means Thurmaduke has more accurate temperature control for perfect food storage.

Don't buy any food warming equipment until you have made a feature comparison with Thurmaduke. I personally guarantee the complete line of Thurmaduke Food Warmers to have more quality features than any other made. *Write me for complete information on Thurmaduke Food Warmers, Standard Sectional Cafeteria Counters, and a free Feature Comparison Chart.* Meanwhile, ask your nearby Thurmaduke dealer to show you how Thurmaduke Waterless Food Warmers protect your reputation for serving fine food.

M. P. Duke
PRESIDENT

DUKE
SETS THE STANDARD
For The Food Serving Industry

THURMADUKE

DUKE MANUFACTURING CO. • DEPT. No. 112 • ST. LOUIS 6, MO.

Physical Strain Eliminated With Morgue Tray Lift

A morgue tray accessory to the Porto-Lift is now available for the handling of a corpse without strain to personnel. The new accessory is a stainless steel tray suspended from a chromed steel support bar which is used with the Porto-Lift. The tray is placed beneath the body on removal from the bed for transport to the morgue. Transfer from the stretcher to the autopsy table or morgue storage box is quickly and effortlessly handled by connecting the tray to the sturdy Porto-Lift frame by the simple hydraulic controls. The swivel caster mounting gives complete mobility in handling. Body transfers can thus be handled by a single attendant without strain. Morgue trays remain with each body until final disposition is made, thus simplifying all phases of handling. **Porto-Lift Mfg. Co., Roscommon, Mich.**

For more details circle #656 on mailing card.

Malerich Stand Is All-Purpose Unit

The Malerich Multi-Purpose Surgical and Treatment Stand is a new development in this type of equipment. Invented by Dr. J. A. Malerich of St. Paul, Minnesota, the one stand is designed to serve as an anesthetic stand, leg rest, arm rest, head rest, solution stand, hypodermy support, instrument table, plaster and casting basin stand, suturing table, extremity prep tray and basin or other requirement. Two different sized curved rests provide support for an arm, leg or head in any desired position. They are removable and interchangeable and fit easily into slots on any of the four sides

of the stand. More than fifty different combinations of positions are possible. The stand can be wheeled to the patient's bedside or the treatment room and treatment can be given from sitting positions. The work surface is adjustable in height. **Wilson Mfg. Co., Columbus, Georgia.**

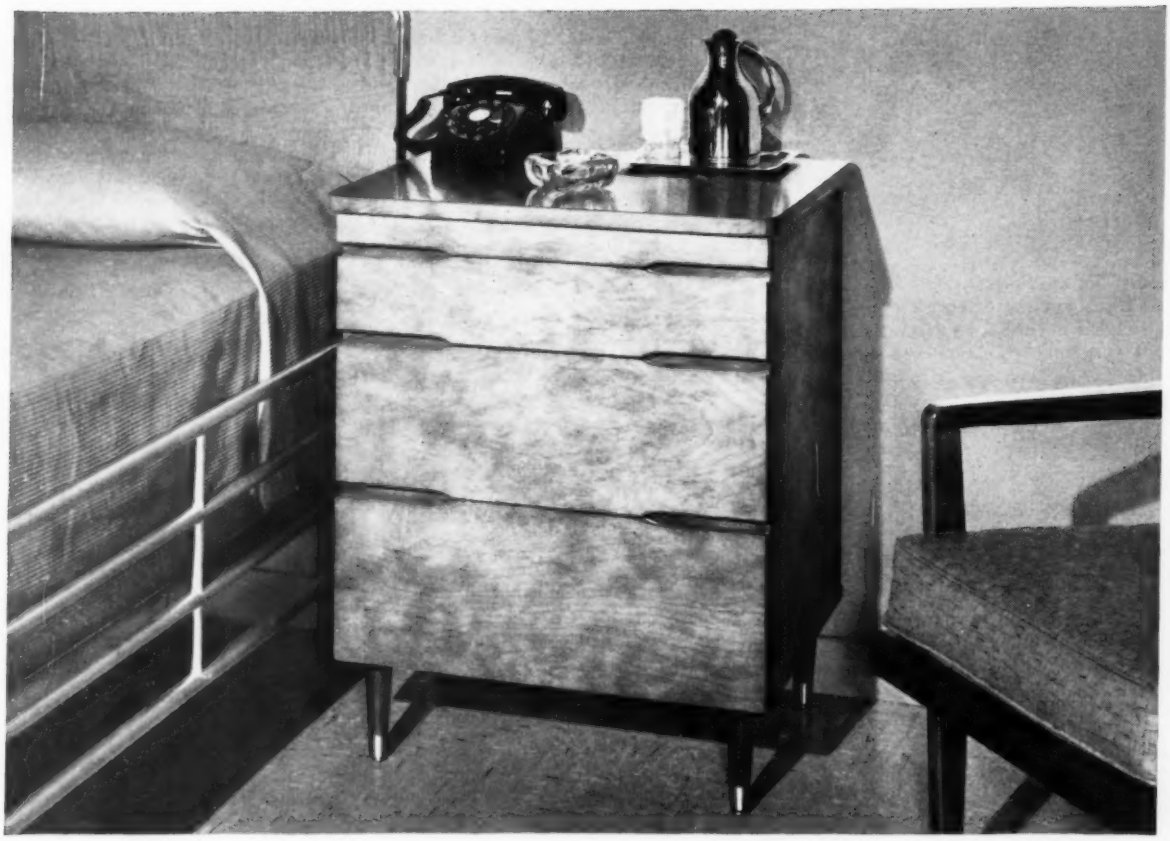
For more details circle #657 on mailing card.

Push-Button Illumination for Research Microscope

The "R" series of microscopes developed by Bausch & Lomb now have push-button illumination for faster and easier specimen analysis. Incorporating many of the standard Dynoptic research design features, the new microscopes feature several major new developments in substage equipment. The achromatic variable focus container on the new model features push-button illumination, providing speed, accuracy and ease of operation through the use of unusually large lenses in the condenser, a graduated numerical aperture scale and a knurled ring for setting the lens system. The new series has other features for more effective use. **Bausch & Lomb Optical Co., 635 St. Paul St., Rochester, N.Y.**

For more details circle #658 on mailing card.

(Continued on page 218)



Field's solution for saving room space

Today's crowded hospital rooms demand a new furnishing approach. And Field's, ever alert to hospital requirements, has the perfect solution—a bedside chest that eliminates the need for a dresser in hospital rooms.

This new Field's bedside chest provides space for the patient's clothes and other possessions in 3 ample drawers, and at the same time offers the convenience of a bedside cabinet—all in one compact unit. And just look at all these outstanding features Field's designed into it:

- A bedside height of either 30″ or 33″, a depth of 19½″ and a width of 24″—a size that easily fits in place of the bedside cabinet.
- A large Formica covered top surface (much larger than those on conventional cabinets) easily accommodates telephone, radio, water—everything a patient wants close at hand.
- A sturdy sliding shelf—also Formica-covered—has metal glides for easy, quiet operation when the doctor or nurse needs a clear, level place for equipment or instruments.
- A push-in cylinder lock that makes the top drawer a safe place for the patient's valuables.
- The roomy center drawer accommodates patient's clothing—a whole suitcase full.
- The large bottom drawer is ventilated and can be used for utensils.
- No hardware—no protruding drawer pulls to catch on uniforms, wheelchairs.
- Finest cabinet work of birch with sycamore drawer interiors.
- Formica and wood surfaces in Harvest tone color—all surfaces resistant to fingernail polish remover and alcohol. Other colors available.
- Sturdy turned legs with brass ferrules permit easy floor maintenance.

For more information, write us, or visit our showrooms in the Merchandise Mart.

MARSHALL FIELD & COMPANY · CONTRACT DIVISION

MERCHANDISE MART · CHICAGO 54, ILLINOIS · WHITEHALL 4-1991

WHAT'S NEW

Royal Hi-Lo Bed Is Quickly Positioned

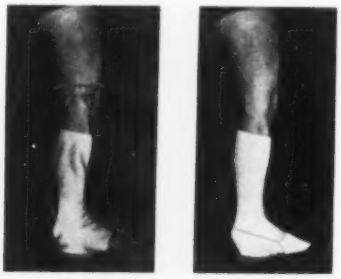
Speed of operation for placing patients in Trendelenburg or Fowler positions is claimed for the new Royal Hi-Lo Bed. Positive control of head and foot heights simultaneously or independently is afforded with the fast, spring-assisted lift, single fold-away crank, easy-to-reach clutch and a single shaft. For Trendelenburg position a simple finger pull throws out the clutch to keep the head down as the crank is quickly turned at the foot. Fowler position is as easily achieved. The Hi-Lo Bed has a minimum elevation of 18 inches and adjusts to 27-inch spring fabric height. It is available in six models. **Royal Metal Mfg. Co., 175 N. Michigan Ave., Chicago 1.**

For more details circle #659 on mailing card.

Comfort Aids for Plaster Cast Patients

Two developments are available to add to the comfort of the patient wearing a plaster cast. The Toe-Cap gives the desired protection and warmth needed in cold weather and keeps the toes clean when the patient has a walking cast. It is held in place by an elastic band and can be removed for washing as needed.

The second development for the patient's comfort is the Shower Shield. This disposable plastic boot is a water



tight cover to protect the cast when the patient bathes. It also is held in place with an elastic band. **Orthopedic Frame Co., Kalamazoo, Mich.**

For more details circle #660 on mailing card.

Cardio-Encephalograph in Portable Unit

Designed for use in the operating room in determining cardiac condition and depth of anesthesia during surgery, the new Cardio-Encephalograph is of advantage in a wide variety of other situations. The two-channel unit occupies minimum space and is readily portable. It has instantaneous speed change, without shifting gears, and a foot switch is available for remote control of the ap-

paratus. The permanent record is compact and fan-fold.

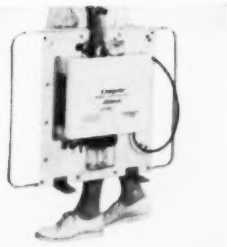
The instrument may be used for bedside evaluations as well as operating room and laboratory work. Cost of recording is low and the new GME ink recording system eliminates plugging of pens, permitting either routine or occasional use. **Gilson Medical Electronics, 714 Market Place, Madison 3, Wis.**

For more details circle #661 on mailing card.

(Continued on page 221)

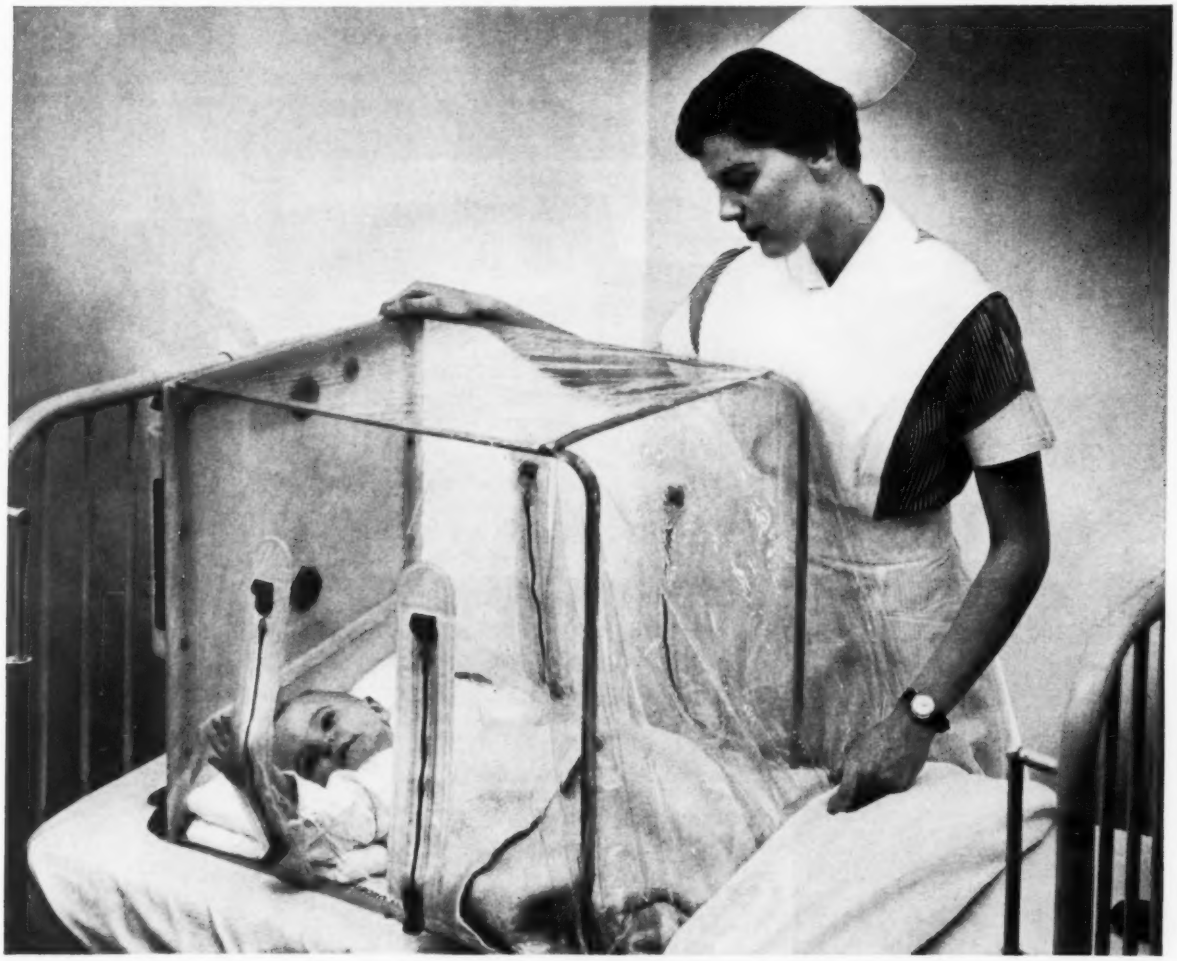
No wonder it's **standard equipment**

The CROUPETTE® is standard equipment in about 3,000 hospitals and 96 per cent of U. S. medical schools. First "cool vapor" croup tent, the CROUPETTE consistently excels all others in comfort, convenience and safety. The fresh, moisture-saturated air is effectively cooled and oxygenated by exclusive CROUPETTE forced circulation. Aerosol or oxygen therapy may be easily administered. With no moving parts, the CROUPETTE is as simple as it is safe and efficient.



Light, compact, portable.
Includes spare atomizer.

Visibility and accessibility are CROUPETTE features. Cooled, supersaturated, aerated vapor provides immediate relief and comfort.



The Croupette®

Cool-Vapor and Oxygen Tent By **AIR-SHIELDS, INC.** *Hatboro, Pa. OSborne 5-5200*

For information or orders, call us collect from any point in the U.S.A.

WHAT'S NEW

Electric Dispenser for Photocopy Paper

Designed for use in conjunction with the Apeco Dial-A-Matic Auto-Stat photocopying machine, the new Apeco Eject-O-Matic paper dispenser automatically ejects one sheet of photocopy paper at a time with just a touch of the electric ejector bar. It protects photocopy paper from light exposure and features an easy loading principle with simple adjustments to hold 100 sheets of any standard size. **American Photocopy Equipment Co., 1920 W. Peterson, Chicago 26.**

For more details circle #662 on mailing card.

Caps and Masks of Preshrunk Muslin

Typical of the new line of caps and masks for surgeons and nurses is the Scottie O.R. Cap pictured. Caps and masks are made of preshrunk, finely woven muslin of specific weights best suited for each requirement. They are constructed to withstand repeated laundering. The Scottie Cap has adjustable tie straps in back to provide a snug, comfortable fit. **Acme Cotton Products Co., Inc., 245 Fifth Ave., New York 16.**

For more details circle #663 on mailing card.

Improved Mazzini Slide of Clear Glass

Crystal clear glass is used in making the improved Mazzini type slide designed for serological testing and analysis. The slide has many laboratory uses and measures 90mm long by 57mm wide by 3.5mm thick. Each of the twelve rings is raised above the flat surface and numbered. One end of the base is finely ground to provide an area for marking identification data or labeling. Two strips of glass molded to the underside of the base prevent accidental scratching of the surface and marring of table tops. The slides were developed as the result of research in hospital and other laboratories. **Mercer Glass Works, Inc., 725 Broadway, New York 3.**

For more details circle #664 on mailing card.

Bag Closette Keeps Materials Sterile

Sterile autoclaved materials remain sterile when bags and tubing are protected by the new Bag Closette. A paper covered metal strip, the Closette is an easy, rapid and inexpensive means of closing bags of all shapes, sizes and

forms, whether made of paper, glassine or other materials. They are effective in closing both ends of all types of tubing and can be used conveniently in tying down paper nipple caps used in terminal sterilization of formula.

A paper specifically developed for autoclave use is used in the Bag Closettes which can in no way puncture the bag or become loose during normal handling. The simple method of opening the Closettes eliminates the possibility of contaminating bag openings. **Aseptic-Thermo Indicator Co., 11471 Vanowen St., North Hollywood, Calif.**

For more details circle #665 on mailing card.

(Continued on page 222)

Single-Brush Hilboy Features Low Design

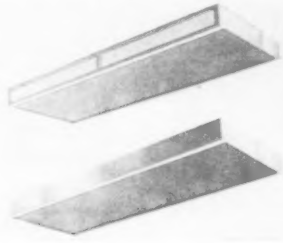
Measuring only 9½ inches in height, the single-brush Hilboy floor machine

is designed for all floor cleaning, including areas usually inaccessible. Many interesting engineering innovations have gone into the construction of the new Hilboy. The specially developed low-design motor by G-E is built into a body which can reach under furniture and equipment for scrubbing, polishing, steel wooling, sanding or grinding floors. The pistol-grip handles are scientifically designed to reduce hand fatigue and to start the motor with ordinary finger-tip pressure. Individually suspended wheels are instantly retractable for easy portability. The direction of rotation can be reversed by a simple switch action to retard brush wear. The new Hilboy is available in 17 and 21-inch diameters. **Hillyard Chemical Co., St. Joseph, Mo.**

For more details circle #666 on mailing card.

Slimlux Luminaire for Close-Ceiling Mounting

Available in a large variety of models, the new line of Guth Slimlux fixtures is only four and one-quarter inches deep. The top level of the shallow-depth luminaire rests snugly against the ceiling.



Units are available in two light or four light widths, in four-foot or eight-foot lengths, with Gratelite Louver Diffuser, metal cross baffles or Pattern 70 Low Brightness lens. All Slimlux fixtures are heat tested and have extra rugged construction. They are fabricated of heavy gauge, zinc plated and bonderized steel **Edwin F. Guth Company, 2615 Washington Blvd., St. Louis 3, Mo.**

For more details circle #667 on mailing card.

(Continued on page 224)

New! Acclaimed at the American Hospital Association Convention!

McKESSON'S Nurse's Station Unit

Organizes 12 feet of shelf space into dust-free, compact 2-foot floor space —puts everything in finger-tip reach!

THIS beautiful unit takes so little space that every nurse's station—on each floor of a hospital—can be an organized, complete station all in only 2 feet of floor space. It saves time, work and footsteps for nurses. It keeps order at busy nurse's stations.

The two top sections open in one motion to offer at-a-glance selections of pharmaceuticals on door-within-door shelf space. The flexible lower section has six drawers for ampule storage (also available with lower section to hold 6 one-gallon containers).

Locked narcotics cabinet on the inside of the lower door may be opened only by the head nurse's key. For safety control, the two outer doors are also locked.

DIMENSIONS: HEIGHT, 7'—WIDTH, 2'—DEPTH, 18"

Available in your choice of colors

Hospital White; Blossom Pink; Meadow Green; Powder Blue. Finished in several coats of hard, gleaming, hand-rubbed lacquer enamel.

Nurse's Station Unit is another example of McKesson's careful, scientific planning to help hospitals give their patients the best and most efficient service.

* * *

Personalized Service – Let the McKesson Hospital Representative tell you about the *personalized* free service he can offer you, tailored to the needs of your hospital.

FOR FURTHER INFORMATION on McKesson's Nurse's Station Unit and Hospital Pharmacy fixtures and planning, write: Hospital Department, McKesson & Robbins, Inc., 155 E. 44th St., New York 17, N. Y.

HOSPITAL DEPARTMENT
McKESSON & ROBBINS INC

Serving America's Hospitals... BETTER... by McKESSON

WHAT'S NEW

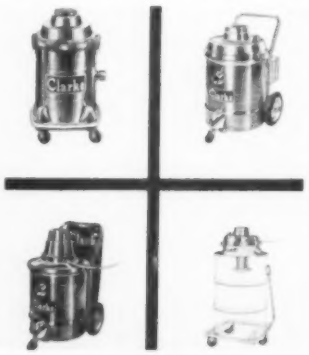
Insulated Bowl for Hot or Cold Foods

Designed for tray service in serving hot or cold foods, the new Number S1151VH insulated bowl is attractive as well as functional. Made of stainless steel, the bowl has a dome shaped cover and can be used for serving soup or ice cream. The stainless steel provides not only attractive appearance, strength and durability but ease of maintenance. **Legion Utensils Co., Inc., 21-07 40th Ave., Long Island City 1, N.Y.**

For more details circle #668 on mailing card.

Vacuum Cleaner Line Is Re-Designed

Six all-new units are included in the complete new line of Clarke heavy duty wet-dry vacuum cleaners. Ranging from a ½ h.p. model with 2½ gallon wet and ½ bushel dry capacity to a 1½ h.p. giant conversion unit, the line has a number of new features. Included are stainless steel tanks, polished aluminum heads and job-designed turbines for extra powerful suction and fast operation. The new "feather-touch" push switch is easy to operate and new clamp handles hold the head firmly on the tank and serve as convenient handles when lifting the head.



Other features make the new line exceptionally efficient in picking up dust, dirt and liquids and they will clean virtually everything from floor to ceiling. A range of sizes is available with special, newly designed tools for practically every cleaning job. **Clarke Sanding Machine Co., Muskegon, Mich.**

For more details circle #669 on mailing card.

All-Purpose Folding Table with Honeycomb Reinforced Top

The new Krueger all-purpose folding table features a lightweight, hard-surfaced top composed of a honeycomb core. The core is reinforced with a five-ply hardwood "H" frame flanked with basswood side members to provide a rigid, durable and solid anchorage for leg hardware securement. Welded steel tubing legs of 1¼ inch diameter fold flat for storage and handles are incorporated for easier handling. Tops are available in brown tempered Masonite or tan-birch finished Resilyte plastic in 30 or 36 inches wide by 72 or 96 inches long. Standing height is 29 inches. **Krueger Metal Products Co., Box 1097, Green Bay, Wis.**

For more details circle #670 on mailing card.

(Continued on page 226)

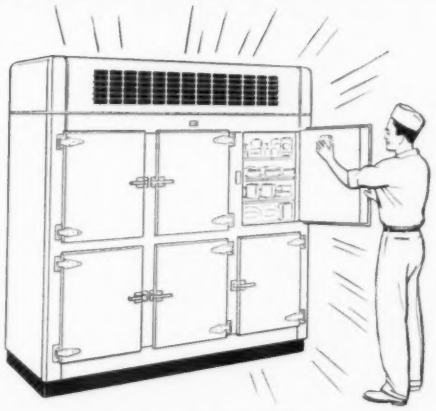
Standard of all Comparison

HERRICK STAINLESS STEEL* REFRIGERATORS

Provide the Very Ultimate in Sanitary Food Storage

HERRICK Stainless Steel Refrigerators contribute an important "Plus" to overall kitchen cleanliness. Inside and out, mirror-smooth surfaces resist dirt and stains . . . wipe sparkling clean with a damp cloth. Open edges and corners are eliminated. Correct temperature and humidity prevent food spoilage. You can depend on HERRICK. Write for name of nearest supplier.

*Also available with white enamel finish



HERRICK MODEL SS40B
Self Contained Reach-In

HERRICK Stainless Steel is Impervious to Food Acids

Solid 20-ga., type 18-8 with permanently beautiful No. 4 polish. Won't crack, chip or peel.

EASY TO MAINTAIN

- All surfaces, including door fronts and interior liner, have smooth, rounded corners.
- Door liners are one piece construction.
- No open edges or dirt-catching corners.
- Breaker strips have tight plastic seal.
- Shelves are removable for cleaning.
- Drain trap is easily flushed out.

HERRICK manufactures a complete line of:

Reach-In Refrigerators

Remote Freezers

Walk-In Coolers

HERRICK REFRIGERATOR COMPANY • Waterloo, Iowa
Dept. M Commercial Refrigerator Division

Typical Installations

HERRICK Refrigerators are Performance-Proved at:

Abilene State Hospital
Abilene, Texas

St. Michaels Hospital
Milwaukee, Wisconsin

Jewish Hospital,
St. Louis, Missouri

Virginia Municipal Hospital
Virginia, Minnesota

East Texas T. B. Hospital,
Tyler, Texas

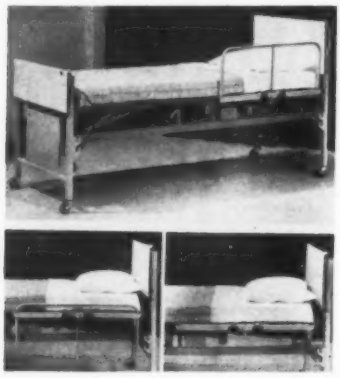
Michael Reese Hospital,
Chicago, Illinois

Boone County Hospital,
Boone, Iowa

WHAT'S NEW

Sliding Safety Rail Is Versatile Unit

The new Shampaine Two-Piece Sliding Safety Rail does the work of several units. The Clamp-On or Bolt-On supports can be installed semi-permanently or permanently on several beds and the rail section transferred quickly and easily from one to another. The rail section locks into the support or is quickly released with minimum effort. Installation and operation are noiseless. The Safety Rail is 34 inches long, raises to 14 inches above the upper spring fabric, lowers to three inches above the rail or can be quickly removed for use on another bed supplied with supports. **Shampaine Co., 1920 S. Jefferson Ave., St. Louis 4, Mo.**



For more details circle #671 on mailing card.

Fresh Lemonade in 18-Ounce Can

Sunkist now offers frozen lemonade in 18-ounce cans designed especially for institutional use. The new size provides easier handling, requires less storage space and makes a refreshing drink readily available in quantities with little preparation. Cost and quality control are possible as the new size will make one gallon of lemonade at a cost less than three cents per 10-ounce glass. **Sunkist Growers, Inc., 707 W. Fifth St., Los Angeles 13, Calif.**

For more details circle #672 on mailing card.

Mattress Covers of Non-Allergenic Plastic

The "Dura-Weld" Contour Plastic Mattress Covering is designed to slip easily over the mattress. The cover can be quickly slipped off for washing, is boilable and is said to retain its softness after years of use. All seams are electrically welded and the contour type mattress cover goes over the mattress without effort, providing a snug fit without fasteners. Made of non-allergenic plastic, the covers are fire resistant, waterproof and sanitary. **Beckik Products, Inc., 650 Eustis St., St. Paul 14, Minn.**

For more details circle #673 on mailing card.

(Continued on page 228)

NEW Ideal COMBINATION

. . eliminates loose ends in CENTRAL FOOD SERVICE

IDEAL Mealmobile, Model 9020-BCT with built-in beverage dispenser and mechanical refrigeration.

The new IDEAL Mealmobile with mechanical refrigeration and built-in beverage dispenser, together with the new Idealmobile, Model FS-100, hot food assembly unit, now make it possible for you to have a complete food service system that is thorough, fast and efficient.

The Mealmobile with its mechanical refrigeration, can now be used as a cold food storage unit. This permits the loading of salads and other cold items well in advance of food serving time and eliminates peaks and valleys in the work load in the kitchen. The new IDEAL Mealmobile in combination with the new Idealmobile hot food assembly unit, enables you to move foods directly from the hot food preparation area to the most convenient assembly area — thus speeding up food service.

The complete IDEAL centralized food service system introduces a cyclical operation in the movement of food from kitchen to patient . . . done the same way every time. And efficiency increases each time!

This IDEAL combination offers efficient centralized food service for all hospitals—regardless of size. Additional units may be added to meet your needs —present and future.

Idealmobile Model FS-100 hot food assembly unit

★ Visit our booth 601 at the American Dietetic Show, October 22-24.

Write for assistance in your kitchen planning

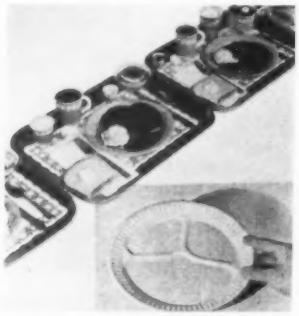
Ideal® HOSPITAL EQUIPMENT
Found in Foremost Hospitals

Made only by the
SWARTZBAUGH MANUFACTURING COMPANY
MURFREESBORO, TENN.

WHAT'S NEW

Partitioned Plate in Matched Food Service

A ten-inch partitioned plate is now available in the Dixie Matched Food Service for Hospitals. The new plate is uncoated, yet sturdy enough to withstand cutting meats and to resist absorption of gravies. Other plates in the serv-

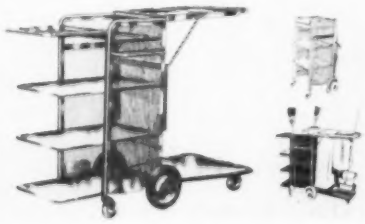


ice, both plastic coated and uncoated, include six, seven and nine-inch sizes. The disposable food service is offered to speed clean-up time, save dishwashing and eliminate breakage. The completely sanitary items are quiet in use, require minimum storage space and save tray weight. **Dixie Cup Co., Easton, Pa.**

For more details circle #674 on mailing card.

Electrically Welded Linen Truck Folds Easily for Storage

The speed and ease with which it folds are features of a new Linen Truck recently introduced. Made of electrically welded steel, it has three smooth shelves for carrying quantities of clean linen and



is provided with two large canvas bags for carrying trash and soiled linens. The two large steel trays above the shelves hold supplies such as soaps, cleansers and other cleaning materials. Cleaning tools such as brooms and mops are carried on either side of the truck.

Two 10-inch ball bearing wheels with an extra set of swivel casters at each end make the truck roll easily and permit it to be turned completely around. The wheels move readily and noiselessly over all types of floors. When folded the truck occupies approximately the space of an office chair. When open it measures 57 inches long, 25 inches wide and 42 inches high. **The Paul O. Young Company, Line Lexington, Pa.**

For more details circle #675 on mailing card.

(Continued on page 230)

Why don't you talk to the men at Cumerford about raising the money?

Wherever you look these days, beautiful new hospitals are going up.

How about you—are you going to get that new wing —nurses home—children's building?

Why don't *you* talk to the men at Cumerford about raising the money?

Cumerford campaign directors, right now are raising money for hospitals throughout the country. **A recent campaign in the capitol city of Missouri, Jefferson City, produced an astonishing over-subscription of $260,000 — the goal of $350,000 was surpassed early in the campaign and total gifts of over $610,000 came in!**

Call or write Cumerford and a representative will meet with you and help you crystallize your problem at no cost or obligation. Cumerford, Incorporated, America's *growing* fund-raising consultants, 912 Baltimore Avenue, Kansas City 5, Missouri. Telephone BAltimore 1-4686.

WHAT'S NEW

Waterproof Sheeting Is Disposable

Plastic sheeting at a price which permits disposing of it after use is now available. Sanitation is assured with the new product which is extremely thin, yet strong enough for the heaviest body when used as an undersheet. It is nonrattling, water, oil and acid proof and resists chemicals. The new sheeting comes in rolls 200 feet long and 50 inches wide. It is intended for use as a disposable waterproof covering in the laboratory, operating room, nursery, and mortuary, as an inexpensive odor tent, to cover pillows, as a bassinet and bed sheet and as a disposable under pad for incontinents. **Busse Plastics, 64 E. 8th St., New York 3.**

For more details circle #676 on mailing card.

Compact Electrocardiograph Incorporates Transitor

Tiny transistors are used in place of most of the vacuum tubes in the new Model 300 Visette electrocardiograph. The result is a compact, lightweight unit providing full diagnostic accuracy with extreme portability. Modern electronic components and technics, a much smaller, lighter recording assembly and circuits contained on printed wiring panels the size of calling cards are some of the new developments used.

Numerous developments to simplify operations are also features of the new Visette. They include two basic controls, push-button grounding, automatic shut-

off of power when the cover is closed, quick, easy chart reloading and other advances. **Sanborn Co., 175 Wyman St., Waltham 54, Mass.**

For more details circle #677 on mailing card.

Anchor Hinge for Exterior Doors

Designed for hanging exterior doors of wood or metal in public buildings, the new Anchor Hinge is made of wrought steel in five by four and one-half-inch size. It is adaptable to all doors one and three-quarters to two and one-quarter inches thick where a door holder or door closer, in conjunction with other conditions, causes severe strain on hinges, particularly the top one. Of extra heavy gauge, the Anchor Hinge is equipped with four bearings and is available highly polished and triple plated to resist rust, or bonderized and prime coated for painted finishes. **McKinney Mfg. Co., 1715 Liverpool St., Pittsburgh 33, Pa.**

For more details circle #678 on mailing card.

Lens Bracket Developed for Wide Screen Projection

The Superama '16' lens for wide screen projection is designed for both taking and projecting regular 16mm wide screen motion pictures. Brackets to fit Bell and Howell, Ampro and Victor Arc projectors are now available for the dual purpose lens. **Radiant Mfg. Co., 2627 W. Roosevelt Road, Chicago 8.**

For more details circle #679 on mailing card.

(Continued on page 232)

WHAT'S NEW

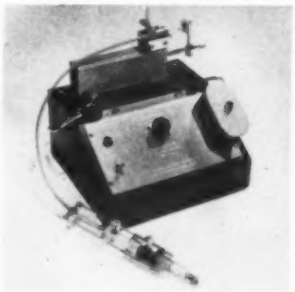
Sterilizer-Cooler for Smaller Formula Units

Designed for use in formula units serving 40 or less bassinets, the new Southern Cross Low Pressure Sterilizer-Cooler is available for either steam or electrical operation. The completely automatic cycling sterilizes and cools 144 four or eight-ounce bottles in the cabinets at one time. The sterilizing period is designed to produce bacteriologically safe formulas in minimum time while preventing carmelization or scumming. **The Southern Cross Mfg. Corp., Chambersburg, Pa.**

For more details circle #680 on mailing card.

Constant Flow System for Blood Withdrawal

Blood can be drawn from arteries and veins at a constant rate with the new Colson Constant Flow System. The system can also be used for infusing materials into the bloodstream. An electroni-

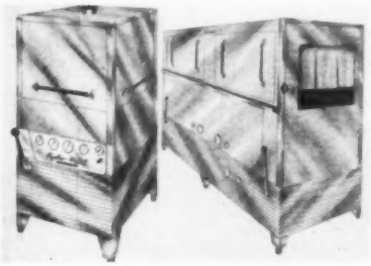


cally controlled constant speed motor drives a lead screw which operates a standard hypodermic syringe at a constant velocity to assure uniform flow. Flow rates as low as 4 cc. per hour and as high as 40 cc. per minute are possible with the system. Designed specifically for use with the Colson Cuvette Densitometer which measures cardiac output, the device has many other applications in a variety of clinical or research situations. **The Colson Corporation, Elyria, Ohio.**

For more details circle #681 on mailing card.

Steel and Aluminum in Automatic Dishwashers

The new 1957 Clean-Lined Hydro-Wash Automatic Dishwasher line is con-



structed with stainless steel cabinets combined with aluminum panel skirts. Discoloration is not a problem with the new units and the attractive clean lines of the styling are functional and practical. All models have large removable panels which allow easy accessibility to all internal parts for service and maintenance.

Two of the seven models offered in the new line are illustrated. The space-saving cabinet type shown handles up to 1800 dishes per hour. The larger eight-foot double tank, completely automatic conveyor model will handle up to 7500 dishes per hour. Intermediate sizes are available for every institutional dishwashing requirement. **Peters-Dalton, Inc., 17900 Ryan Rd., Detroit 12, Mich.**

For more details circle #682 on mailing card.

(Continued on page 234)

Yes . . . the administrator's pretty proud of himself. And rightly so! It's not every day you get to make a statement like that. Especially to new board members!

They're impressed all right. *They* know the value of nursing time. And, like the administrator, they know it shouldn't be wasted pushing pencils. But how else can a nurse initiate her requests for service . . . how else can she create the facts and figures so necessary to sound administration?

This administrator found the answer in McBee Keysort punched-card controls! Today, Keysort Requisition-Charge Tickets furnish him with fast, accurate, complete analysis of income and service-department output . . . reduce the burden at nursing stations to a minimum through less writing, fewer forms, increased accuracy. Using the new, designed-for-hospitals Keysort Data Punch, nurses now *imprint* and *code-punch* pertinent information in *one* operation . . . prepare requisition, work-order record, service-department copy and Keysort charge ticket *at the same time.*

Keysort Requisition-Charge Tickets not only simplify and reduce your nurses' paper-work . . . they are easy to handle in the service departments, ensure promptness and accuracy in posting charges. Here is the modern way to better patient care. The nearby McBee man can show you how it's done. Why not phone him, or write us?

McBEE KEYSORT®

Better patient care through administrative controls

ROYAL McBEE Corporation, Port Chester, N. Y.

Offices in principal cities. In Canada: The McBee Company, Ltd., 179 Bartley Drive, Toronto 16.

WHAT'S NEW

Acoustical Corridor Ceiling Provides Utilities Chamber

A utilities plenum chamber is provided beneath standard long span roof decks with the new Fenestra Acoustical Corridor Ceiling. The false ceiling consists of a 12-foot long acoustical metal pan of 18 gauge steel construction with the Fenestra patented arched acoustical pad as the sound absorbing medium. "Fenacoustical" is 12 inches wide and 1¼ inches deep, each section constructed to support its own dead weight and a 20-pound concentrated light fixture load at mid span. "U" clips over the flanged upstanding legs permit easy installation and removal of the units which provide an acoustical surface similar in texture to Fenestra long span acoustical panels. The metal surface is easy to clean or repaint. **Fenestra, Inc., 2250 E. Grand Ave., Detroit 11, Mich.**

For more details circle #683 on mailing card.

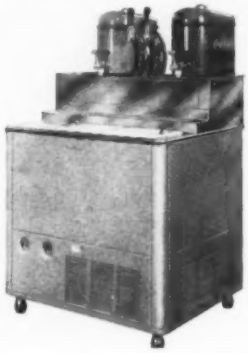
Kent Drum-Seal Facilitates Boiler Clean-Out

Soot and dirt from boiler cleaning or any heavy wet or dry vacuuming job can be handled efficiently with the new Kent Drum-Seal. Developed to fit over any container or drum normally used to hold waste or trash, the Drum-Seal is designed to hold a Kent vacuum head which provides the necessary suction. The Drum-Seal, with a motor head from one of the four Kent Turbo-Vac models, provides an effective boiler cleaning unit with the large container serving as the dirt receptacle. **Kent Company, 736 Canal St., Rome, N.Y.**

For more details circle #684 on mailing card.

Soft Drink Dispenser Combined with Ice-Maker

To assure a constant supply of crushed ice and to save steps in handling ice from a separate supply, a drink dispenser has been combined with an ice maker in one unit. The new Scotsman Drink Dispenser makes its own crushed ice and is capable of serving up to 24 iced drinks



per minute, making it practical for installation in cafeterias, lunchrooms and serving kitchens. The unit is capable of producing 350 pounds of ice per day and storing up to 150 pounds in its stainless steel bin. **American Gas Machine Co., 505 Front St., Albert Lea, Minn.**

For more details circle #685 on mailing card.

Automatic Water Heater Fills Peak Demand

To meet high or intermittent peak demands in institutions where draws of hot water are heavy within a limited time period, the new Ruud Model 300A multi-coil automatic gas water heater is designed for use with natural, mixed, manufactured and LP gases. The unit may be connected to a storage tank, singly or in multiples, to recover tank temperature in intervals between draws. The tank may be horizontal or vertical and the water circulation may be gravity or pump-forced. **Ruud Mfg. Co., 2025 Factory St., Kalamazoo 24F, Mich.**

For more details circle #686 on mailing card.

(Continued on page 238)

TRAVEL-LAV® ... Bedside Facility

... For Self Care of Hospital Patients

Closeup of bedside unit installed at Porter Sanitarium & Hospital, Denver, and Boulder Colorado Sanitarium.

COMPLETE PACKAGED UNIT INSTALLED IN TWO COLORADO HOSPITALS SAVES SPACE ... SAVES WORK ... SAVES HOURS OF NURSING TIME

The bedside unit pictured here places all the facilities for self care within easy reach of the patient. It thus reduces substantially the nursing hours required per patient's day. Convalescence is speeded because the patient is made more comfortable, more self reliant.

The unit is so well planned and so compactly designed, that by including a TRAVEL-LAV fold-away toilet, bed facilities can be increased as much as 50%, in the same building area.

features

- Fold-away wash basin with hot and cold water.
- Ice water fountain.
- Small refrigerator for cool drinks and ice cubes.
- Switch controlling panel with tray table above.
- Concealed Bedpan and Urinal.
- Ash tray ... Towel locker ... Waste receptacle.
- Receptacles for phone and appliances.
- Vanity Desk with mirror & light.
- Room temperature control mounting.
- Clothes wardrobe ... Indirect lighting soffit.

EXHIBITED AT
AMERICAN HOSPITAL ASSOCIATION CONVENTION
ATLANTIC CITY • SEPT. 30-OCT. 3, 1957

TRAVEL-LAV is a revolutionary space saving lavatory facility—ready for final connection to soil pipe and water lines. Made of stainless steel, attractive, sanitary, efficient.

TRAVEL-LAV FOLD-AWAY TOILETS, LAVATORIES AND SHOWER UNITS

Lavatory and Shower Cabinet
MODEL MAS-234
Equipped with fold-away toilet and wash basin and enclosed shower compartment. Medicine cabinet, mirror, storage cabinets, waste receptacle.
Size: 33" x 43" x 84"
Bedpan Flusher supplied as optional equipment.

MODEL FB-220
Fold-away toilet and stationary wash basin. Cabinet base 11" x 26". Height 34".

ANGELO COLONNA, INC.
Designers and Manufacturers
WESTMORELAND AND BOUDINOT STS.
PHILADELPHIA 34, PENNSYLVANIA

WHAT'S NEW

Motorized Intermittent Traction Provided With Nectrac

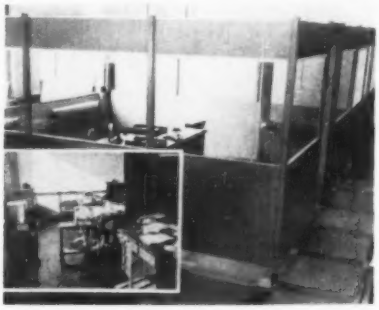
Developed as therapy for relief of many pain syndromes resulting from complications in the area of the cervical spine, the Nectrac provides motorized intermittent traction. It is designed to provide greater traction than is possible with fixed traction and operates at approximately four cycles per minute.

The Nectrac can be hung on the bed, door or wall and is powered by an electric motor. The patient holds the handy operating switch in his hand for quick control of the action. Traction is easily adjusted by turning the knob on the scale. For pelvic traction the Nectrac can be attached to the foot of the hospital bed. **DePuy Mfg. Co., Inc., Warsaw, Ind.**

For more details circle #687 on mailing card.

Modern Space Dividers Installed in Minimum Time

The new 84-inch high Partitioner Space Dividers can convert floor areas into private enclosures in a minimum time without disrupting offices or making a shambles of the area. The Partitioner is a mobile free-standing partition which does not interfere with existing



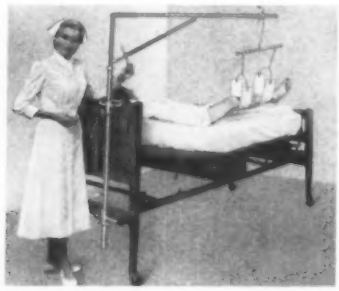
facilities such as air conditioning vents, fluorescent fixtures or sprinkler systems.

Partitioners come in a variety of colors and heights with different types of glass or other materials available as inserts for the steel panels. Panels and posts are interchangeable. **Marnay Sales Div., Rockaway Metal Products Corp., Inwood, N.Y.**

For more details circle #688 on mailing card.

(Continued on page 240)

WHAT'S NEW



Hip Exerciser Fits Any Bed

Designed to help patients become ambulatory in minimum time, the new Chick Hip Exerciser fits any hospital bed, wood or metal. The upper unit, which is separate from the main upright, is mounted to it with roller bearings for frictionless movements. Spring loaded to provide necessary lift to suspend the leg, tension on the spring can be adjusted to the desired degree. With the leg in suspension, effortless movement is possible in all directions for the desired exercise. The unit can also be used for arm and shoulder exercise. **Gilbert Hyde Chick Co., 821 75th Ave., Oakland 21, Calif.**

For more details circle #689 on mailing card.

Pharmaceuticals

Saff

Saff is a dietary supplement indicated in the management of atherosclerosis. It is a palatable emulsion offering a high percentage of unsaturated fatty acids. Saff contains oil pressed from the seeds of the safflower, is compatible with most liquids and can be mixed with all common beverages as well as a number of foods. It is supplied in pint bottles and is lightly flavored. **Abbott Laboratories, North Chicago, Ill.**

For more details circle #690 on mailing card.

Aralen (R)

Aralen phosphate is a new agent for the relief of rheumatoid arthritis. It is indicated for acute or chronic rheumatoid arthritis, with or without adjunctive therapy, spondylitis and arthritis associated with lupus erythematosis or psoriasis. Aralen (R) is supplied in 125 mg. and 250 mg. tablets. **Winthrop Laboratories, 1450 Broadway, New York 18.**

For more details circle #691 on mailing card.

Adrestat

Adrestat is a complete systemic hemostat for the prevention and control of bleeding. It utilizes adrenochrome, the bioflavonoids and vitamin K, providing a dependable, effective means of preventing capillary blood loss. Adrestat is indicated in virtually every bleeding condition and operative procedure. Adrestat capsules are packed in boxes of 30, lozenges in boxes of 20 and Adrestat (F), injectable, in boxes of five one cc. ampules. **Organon, Inc., Orange, N.J.**

For more details circle #692 on mailing card.

Pentrasine

Pentrasine is a new therapeutic agent for the prophylactic management of angina pectoris. It is designed to reduce the severity and frequency of the attacks. Pentrasine is supplied in scored pink tablets in bottles of 100 and 1000. **McNeil Laboratories, Inc., 2900 N. 17th St., Philadelphia 32, Pa.**

For more details circle #693 on mailing card.

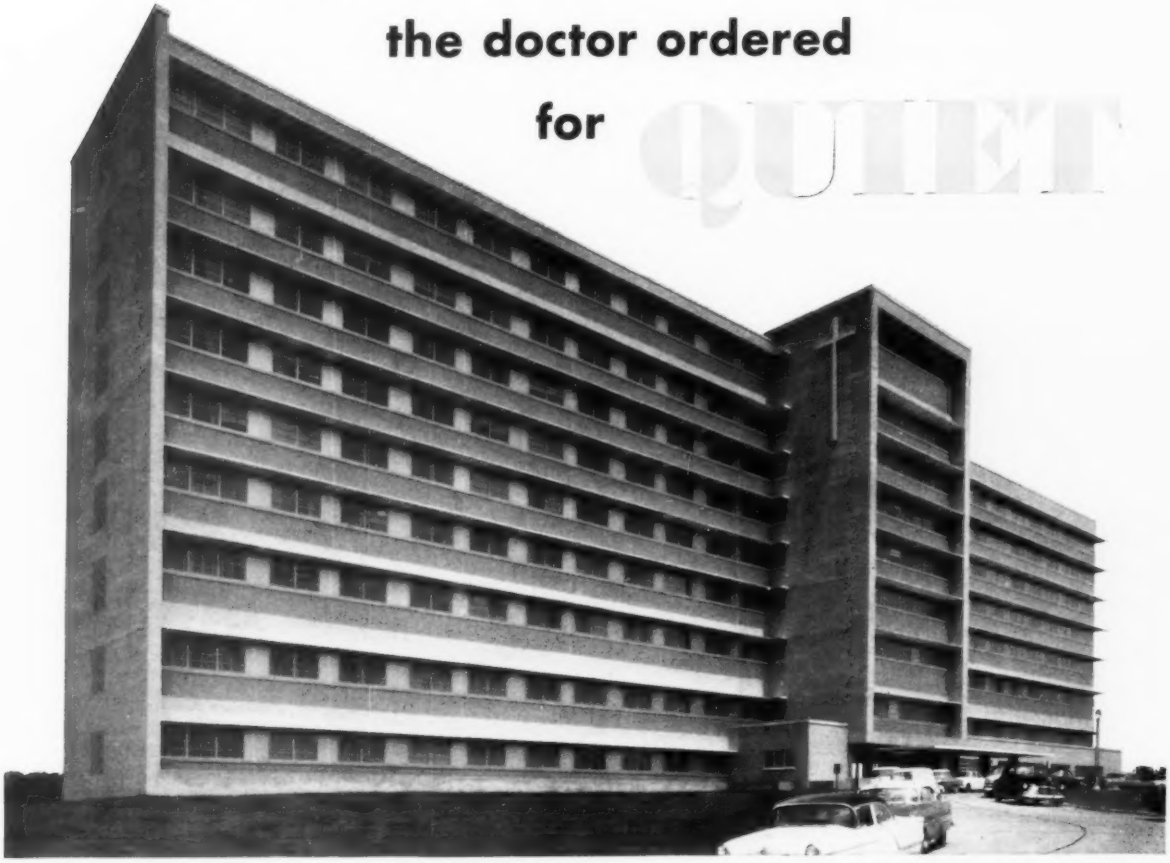
Literature and Services

• **San Pheno X All-Purpose Germicide** is the subject of a new folder published by Huntington Laboratories, Huntington, Ind. San Pheno X is described as a safe, non-specific germicide which kills most of the offending organisms found in the hospital. It is designed for use on floors, walls, furniture and equipment and may also be used on the human body since it is non-irritating and non-sensitizing. It is an excellent disinfectant for kitchens, baths, public rooms and dormitories and is said to be effective against athlete's foot fungus.

For more details circle #694 on mailing card.

(Continued on page 242)

Gold Bond TRAVACOUSTIC . . . just what the doctor ordered for QUIET



St. Vincent Infirmary, Little Rock, Ark. *Ceilings:* 80,000 sq. ft. of Gold Bond Travacoustic. *Acoustical Contractor:* Nevil C. Withrow Co., Little Rock, Ark.

Nurse's Station—as quiet as the rest of the hushed hallway, because handsome Travacoustic absorbs up to 80% of sounds that strike it. No reverberating footsteps . . . no echoing voices.

Nursery—quiet and *safety*, because Gold Bond® Travacoustic tiles are made from mineral fibres—they're incombustible. High light reflection—diffused, without glare.

Cafeteria—quiet with good looks, because Travacoustic tiles are handsomely fissured to resemble travertine stone. Easily vacuum-cleaned or repainted. Mail this coupon for more information.

Gold Bond
BUILDING PRODUCTS

ACOUSTICAL CEILINGS

NATIONAL GYPSUM CO.

NATIONAL GYPSUM COMPANY, Dept. MH-107, Buffalo 2, N. Y.

Please send me the DECIBEL, the booklet that shows how Gold Bond sound-conditioning has solved typical hospital noise problems.

Name *Address*

City *County* *Zone* *State*

WHAT'S NEW

• Two educational aids for the care and handling of surgeons' gloves are now available from the Wilson Rubber Co., Div. of Becton, Dickinson & Co., Canton, Ohio. A wall chart and color sound film, both entitled **"Care and Sterilization of Surgeons' Gloves,"** cover all glove-handling phases from washing to sterilization and storing.

For more details circle #675 on mailing card.

• **"India"** is the title of a new report prepared by the National Cash Register Co., Dayton 9, Ohio, as the result of a recent tour to that country. Color and black and white illustrations tell the story of this land of ancient ways and new ideas, with descriptions of its cities, living standards, culture and religion.

For more details circle #676 on mailing card.

• A 14-minute, 35mm color filmstrip on the nutritional values of turkey is available from the National Turkey Federation, Mount Morris, Ill. The filmstrip, entitled **"Eat Turkey—Feel Perky,"** and the sound disc and illustrated printed commentary give a report on the result of research at Cornell University showing turkey as high in protein and low in caloric content. Colorful and appetizing turkey dishes are presented in the film.

For more details circle #697 on mailing card.

• A new chart on **"How to Select a Fire Extinguisher"** is now available from the Fire Equipment Mfrs. Assn., Inc., Suite 759, One Gateway Center, Pittsburgh 22, Pa. The chart lists basic types of extinguishers and shows at a glance which to use against three cases of fire.

For more details circle #698 on mailing card.

• Designed as an educational tool for maintenance crews, National Sanitary Supply Assn., 139 N. Clark St., Chicago 2, has issued a series of 26 35mm colored slides on **"The Care of Washrooms."**

For more details circle #699 on mailing card.

• Air Diffusers for air conditioning, heating and ventilating systems are the subject of the new **Selection Manual No. 60** brought out by Anemostat Corp. of America, 10 E. 39th St., New York 16. The 80-page booklet contains numerous diagrams, tables and photographs to aid in selections.

For more details circle #700 on mailing card.

• The complete line of **Cordley Electric Drinking Water Coolers** is described in **Bulletin No. 4D** prepared by Cordley & Hayes, 443 Fourth Ave., New York 16.

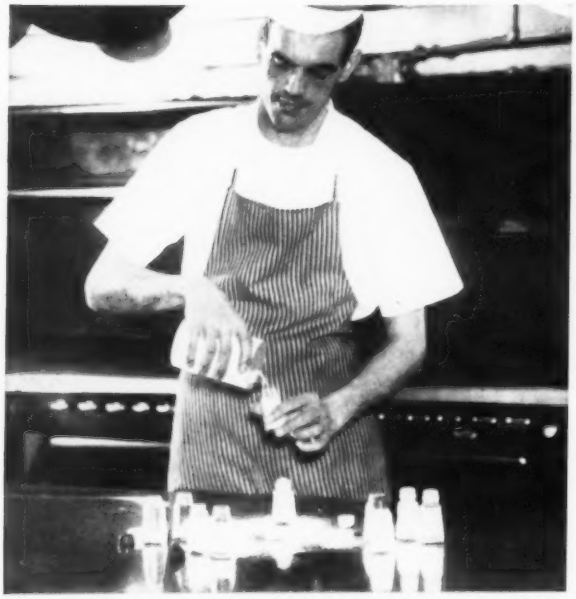
For more details circle #701 on mailing card.

• A 12-page booklet of **Stainless Steel Swing Door Entrances** is offered in **Catalog S-157** by International Steel Company, Evansville 7, Ind. Typical swing door entrances are illustrated with complete architectural details given on stainless steel and "packaged" entrances.

For more details circle #702 on mailing card.

(Continued on page 244)

How Diamond Crystal seasoning packets end danger of cross-infection from dispensers



Old-type salt, pepper and sugar dispensers are often sources of infection. Require constant washing, sterilizing and servicing. Require storage space for both themselves and bulk seasonings.

Diamond Crystal packets are individual seasoning containers. They are disposable and sanitary. Need no servicing. And your patients appreciate their modern convenience.

Exclusive Diamond Crystal salt, pepper and sugar packets are hygienic. Save you money on labor and dispenser replacement

Old-fashioned seasoning dispensers can be an expensive problem to hospitals. They get dirty quickly. Shakers and bowls need constant cleaning. Re-filling. Sterilizing.

Considering the price of labor today, servicing several thousand shakers can really run up your operating costs.

Packets solve problem

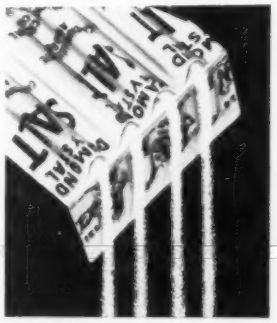
Diamond Crystal seasoning packets are disposable. Hygienic. Eliminate dangers of cross-infection from dispensers.

Each packet contains a generous serving of either pure Diamond Crystal salt; spicy ground black pepper; or fine granulated sugar. When the patient finishes his meal, the packets are thrown away.

There is never the danger of broken glass dispensers when you serve packets.

Exclusive "shaker" action

Only Diamond Crystal packets let you *shake on* seasoning. Their sturdy fluted paper construction allows the same *method* of application as old-type dispensers—without the costly need of regular washing, filling and sterilizing. Your saving on dispenser servicing alone more than makes up for the slight additional cost of packets.



Exclusive "Shaker action" of Diamond Crystal packets allows controlled application of seasoning.

Send for free samples

See for yourself how Diamond Crystal packets can save you time and money. Just mail the coupon below. You will receive a free sample box of 100 Diamond Crystal salt, pepper and sugar packets for your own use by return mail.

Mail this coupon for free samples

Dept. MH.
Diamond Crystal Salt Co.
St. Clair, Michigan

Please send me a free sample box of your seasoning packets.

Name _____

Position _____

Hospital _____

Address _____

City _____ **State** _____

WHAT'S NEW

• Corning Troffer Curved Alba-Lite panels are the subject of a new lighting data bulletin issued by Corning Glass Works, Corning, N.Y. **Bulletin L-110-D** contains full product data, photometric data for 2, 3 and 4-lamp troffers and formulas for illumination level calculations.

For more details circle #703 on mailing card.

• **Booklet CH-1104** is a case history of the time and savings achieved through the use of modern record keeping equipment, including a microfilming camera and shelf files, at Lawrence and Memorial Associated Hospital, New London, Conn. The four-page illustrated case history is available from Remington Rand Division of Sperry Rand Corp., 315 Fourth Ave., New York 10.

For more details circle #704 on mailing card.

• The care and installation of all types of aluminum windows is described in a new booklet, **"The Proper Handling and Installation of Aluminum Windows in Commercial and Monumental Buildings."** Available from the Aluminum Window Mfrs. Assn., 75 West St., New York 6, the booklet gives instructions for handling, glazing, cleaning, loading and storage.

For more details circle #705 on mailing card.

• **Central Vacuum Cleaning Systems** are the subject of a 20-minute color film recently released by The Spencer Turbine Co., 486 New Park Ave., Hartford, Conn. Featured in the film is a demonstration of the Spencer Vacuslot system for quick, dust-free cleaning of dry mops.

For more details circle #706 on mailing card.

• A new **Cafeteria Counter Catalog** offered by Duke Mfg. Co., 2305 N. Broadway, St. Louis 6, Mo., gives complete information and specifications on the Models 30 and 24 standard cafeteria counters. A section containing 16 counter diagrams offers an arrangement to fill most individual needs.

For more details circle #707 on mailing card.

• **Nutting Floor Trucks** are described in a new booklet prepared by Nutting Truck and Caster Co., 1476 W. Division St., Faribault, Minn. 27 different models of two-wheel trucks and four-wheel platform trucks are described as well as many other special duty trucks.

For more details circle #708 on mailing card.

• Information on **O & S Fuel Burning Systems** using gas, oil or a combination is given in a new bulletin issued by Orr & Sembower, Inc., Morgantown Rd., Reading, Pa. Elements comprising the system and actual installations are also discussed along with technical data.

For more details circle #709 on mailing card.

• **"ThermMcCold Hot and Cold Food Banks"** are the subject of a new booklet released by McCall Refrigerator Corp., Hudson, N.Y. The principle of this type of food bank in cafeteria type food service is discussed along with a case history. Pass-Thru and Wall type models are described.

For more details circle #710 on mailing card.

• A color sound filmstrip entitled **"Determining Prothrombin Activity"** describes the theory, use and reporting of the prothrombin time test. Prepared by Warner-Chilcott Laboratories, Morris Plains, N.J., the filmstrip and a recording describe recommended technics and means of avoiding errors.

For more details circle #711 on mailing card.

• Three bulletins describing **Flatwork Ironers** for institutional use have been issued by Chicago Dryer Co., 2210 N. Pulaski Rd., Chicago 39. **Bulletin 2600** gives information on Model 11, Model 16 is described in **Bulletin 2601** and details on Model 24 are contained in **Bulletin 2602.**

For more details circle #712 on mailing card.

• The complete line of **Haws Drinking Fountains and Electric Coolers** is described in **Catalog 1957** available from Haws Drinking Faucet Co., 4th & Page Sts., Berkeley 10, Calif. The booklet also contains information on faucets, accessories and parts and Kramer flush valves, as well as rough-in dimensions and architect's specifications.

For more details circle #713 on mailing card.

(Continued on page 246)

WHAT'S NEW

• A new **Food Service Folder** listing 75 portion-cut meats has been prepared by Armour and Co., Food Service Dept., Chicago 9. Types, grades and sizes of beef, veal, lamb and pork cuts are included with other information designed to increase food service kitchen efficiency.
For more details circle #714 on mailing card.

• Complete specifications on **Ameray aluminum Light Proof Shades** are given in a new brochure now available from Ameray Corporation, 400 Route 46, Kenvil, N.J. Photographs and construction drawings illustrate features of the shades, including extruded aluminum sections with all hardware parts either stainless steel or other non-corrosive material.
For more details circle #715 on mailing card.

• Purkett's new 12-ring 72-inch **Pre-Drying Conditioning Tumbler** is the subject of a new file folder released by Purkett Mfg. Co., Joplin, Mo. Important features of the unit are described and illustrations show the step-by-step operation of the tumbler.
For more details circle #716 on mailing card.

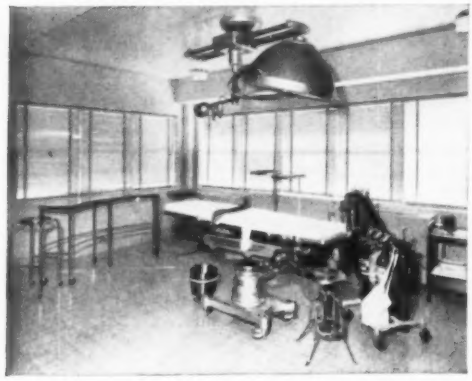
• The new **Blickman Popular Price Coffee Urns** with welded construction are described and illustrated in a new bulletin available from S. Blickman, Inc., Weehawken, N.J. Details of construction, design and capacities of the complete line are given in the leaflet.
For more details circle #717 on mailing card.

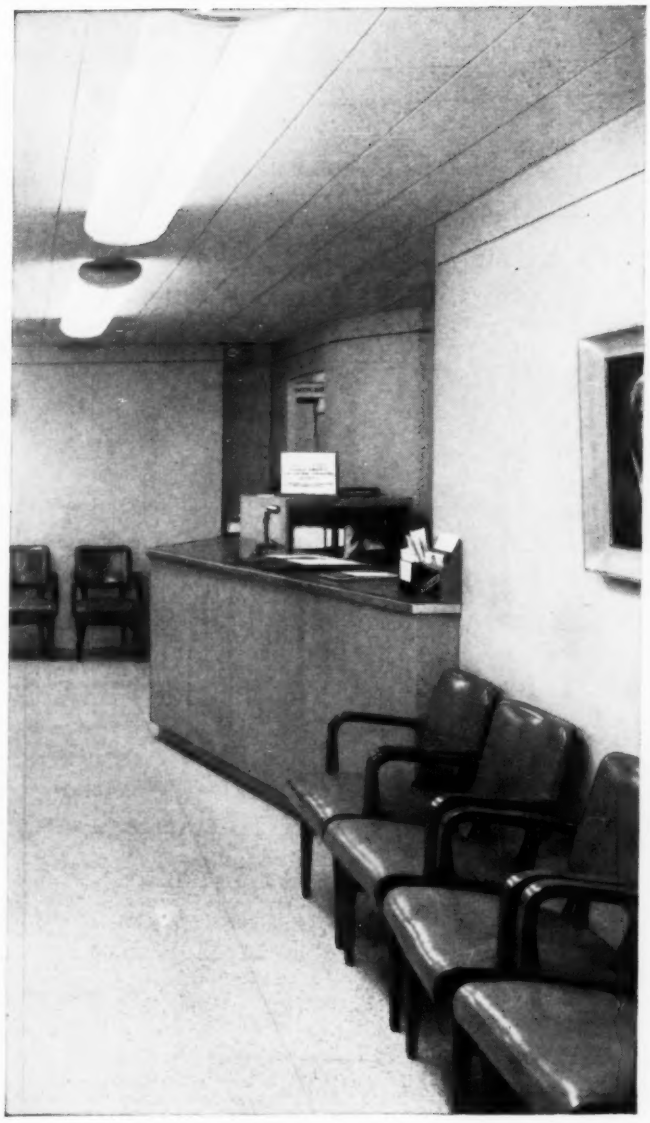
• The **600-page catalog of surgical instruments** issued by The Lawton Company, 425 Fourth Ave., New York 16, has been in preparation for a matter of years. Every major field of surgery is represented in a complete and separate section, listing every surgical instrument used. The complete, comprehensive reference book, devoted entirely to surgical instruments, comprises 23 distinct categories. The catalog is designed for use in hospitals to simplify the complicated procedure of purchasing surgical instruments.
For more details circle #718 on mailing card.

• **Beckman pH Electrodes for laboratory and portable pH meters** are the subject of a new eight-page bulletin recently released by Beckman Instruments, Inc., Scientific Instruments Div., Fullerton, Calif. Labeled **Bulletin 86L**, it is made up in simplified chart form, completely indexed and illustrated as a guide to users in selecting correct pH electrodes.
For more details circle #719 on mailing card.

• **A Photographic Processing Equipment Manual** has been released by Bar-Ray Products, Inc., 209 25th St., Brooklyn 32, N.Y. It includes technical data on stainless steel sinks, temperature control and refrigeration and describes the latest developments in flow cooling, heating and refrigeration equipment.
For more details circle #720 on mailing card.

Texas hospital proves it!





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Latex paints are admired for their beauty, as you know. But economy is an even better reason for using latex paints in your hospital.

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PRODUCT INFORMATION

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American Hospital Supply Corp.
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October, 1957

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NEW!

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